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HEALTH CARE RESOURCE BOOK

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Prepared for the use of Members of the Committee on Ways and Means by members of its staff. This document has not been officially approved by the Committee and may not reflect the views of its Members

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COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS
DAN ROSTENKOWSKI, ILLINOIS, *Chairman*

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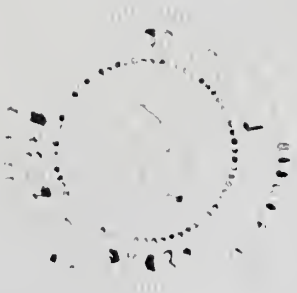

PREFACE

Over the past 30 years, health care spending has grown much faster than spending in the general economy. National health expenditures amounted to $752 billion in 1991, or 13.2 percent of the gross domestic product (GDP), up from 5.3 percent in 1960. If present trends continue, health spending could reach 18.1 percent of GDP by the year 2000.

Rising costs have created increasing pressures on both public and private health care financing programs in a time of limited resources. Federal health programs, including Medicare and Medicaid, accounted for 14.3 percent of total Federal outlays in 1991, and are projected to increase to 21.7 of the Federal budget by 1997. At the same time, double digit inflation in private health insurance premiums has led many employers to reduce health benefits for workers, while many small employers provide no coverage at all.

An estimated 35.4 million people were uninsured in 1991. Generally, the uninsured are young (under age 24); they are poor; and they have ties to the work force (primarily in small firms, in industries with seasonal or temporary employment, and in firms with a lower skilled or less unionized work force). The proportion of the population without coverage appears to have grown since 1980. Recent Congresses have sought to address this trend, chiefly through expansions of Federal/State Medicaid coverage for women and children. Federal and State budgetary constraints prevented any further expansions in the 102d Congress. At the same time, there are concerns that further erosion in the system of work-based coverage could leave many more Americans at risk.

Even insured persons can face substantial health care costs if their insurance does not adequately cover their medical expenses. One study estimated that 13 percent of the privately insured population in 1984 had insurance that was inadequate to protect them from the risk of an extraordinary illness expense. Private health plans and public programs (Medicare and Medicaid) may all, to some degree, leave their enrollees underinsured because of cost-sharing requirements, limits on payment to providers, or uncovered services. The potential exposure of the insured to financial losses may increase if public and private programs reduce benefits in an effort to stem cost increases.

Congress has considered a variety of measures to address the problems of access and cost. Options to cover the uninsured include universal public programs, either State of Federal; requiring that employers provide or contribute to coverage; reforming the health insurance market to make coverage more affordable and available; providing tax assistance to help individuals or groups buy insurance; and expanding the Medicare or Medicaid programs. Proposals to control health care costs are incorporated in many of the access bills and reflect varied strategies such as administrative reform, encouragement of managed care, and overall expenditure limits for medical services.

This chartbook outlines some of the data associated with these issues. It was prepared by a team of Congressional Research Service analysts, including Janet Kline, Mark Merlis, Richard Price, and Richard Rimkunas, with the assistance of CRS technical information specialist, Bud Graves. I would like to thank all those involved in preparing this document for their efforts and their continuing assistance to the Committee on Ways and Means.

DAN ROSTENKOWSKI.

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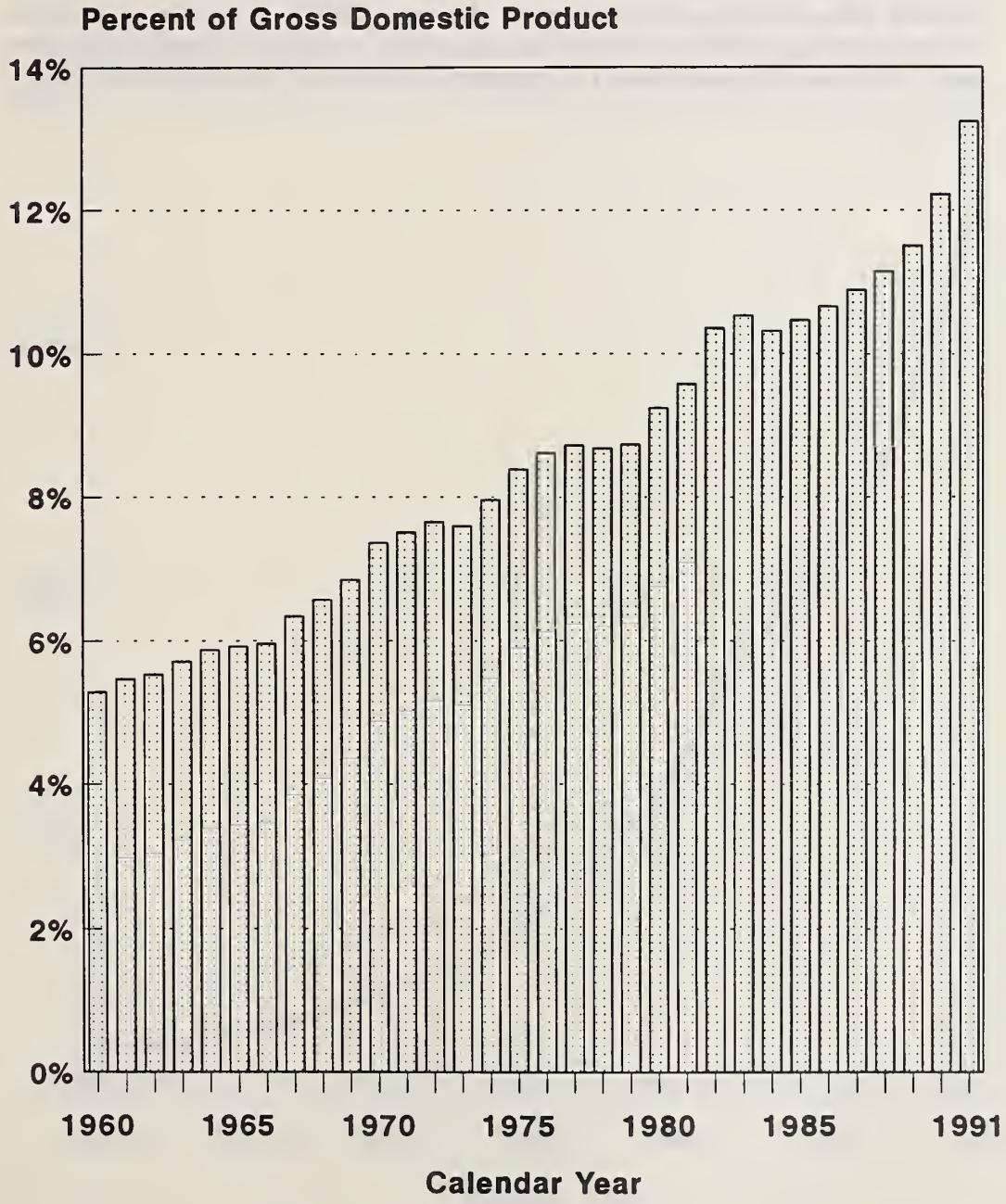
Revised January 1993

Figure 1. National Health Expenditures as a Share of the Gross Domestic Product, 1960 - 1991

In 1960, national health care spending accounted for 5.3 percent of the gross domestic product (GDP). By 1980, it consumed 9.2 percent of the GDP. In 1991, health spending accounted for 13.2 percent of the GDP, up from 12.2 percent in 1990. The 1991 increase in spending marks the seventh consecutive year that health spending grew faster than the overall economy. Between 1985 and 1990, national health spending grew at an average annual rate of 9.8 percent, while the GDP grew at a rate of 6.5 percent. Between 1990 and 1991, health spending increased by 11.4 percent, and the GDP by only 2.8 percent. In 28 of the last 31 years health spending has grown faster than the overall economy.

Figure 1: National Health Expenditures as a Share of the Gross Domestic Product, 1960 to 1991

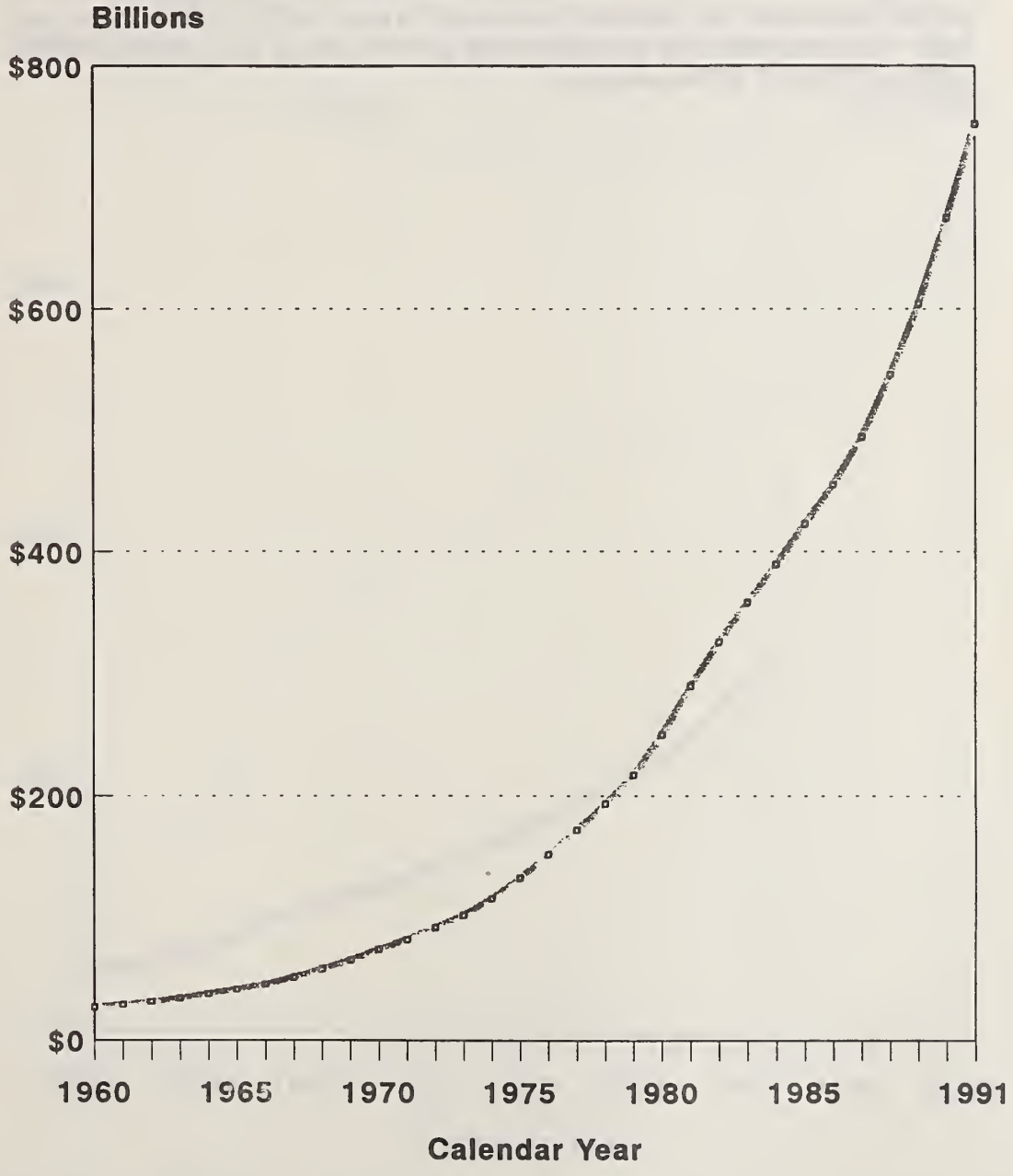


Source: Figure prepared by CRS, based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration

Figure 2. National Health Expenditures, 1960 - 1991

National spending on health care was $27.1 billion in 1960 and $250.1 billion in 1980. In 1991, national health care expenditures reached $751.8 billion. Health care spending grew rapidly in the late seventies and early eighties, with annual growth rates exceeding 15 percent in both 1980 and 1981. Growth rates were more moderate in the mid- 1980's, but have accelerated between 1986 and 1990. The 1991 rate of growth is somewhat smaller than last year. The rate of growth was 11.7 percent in 1990 and 11.4 percent in 1991.

Figure 2: National Health Expenditures, 1960 to 1991

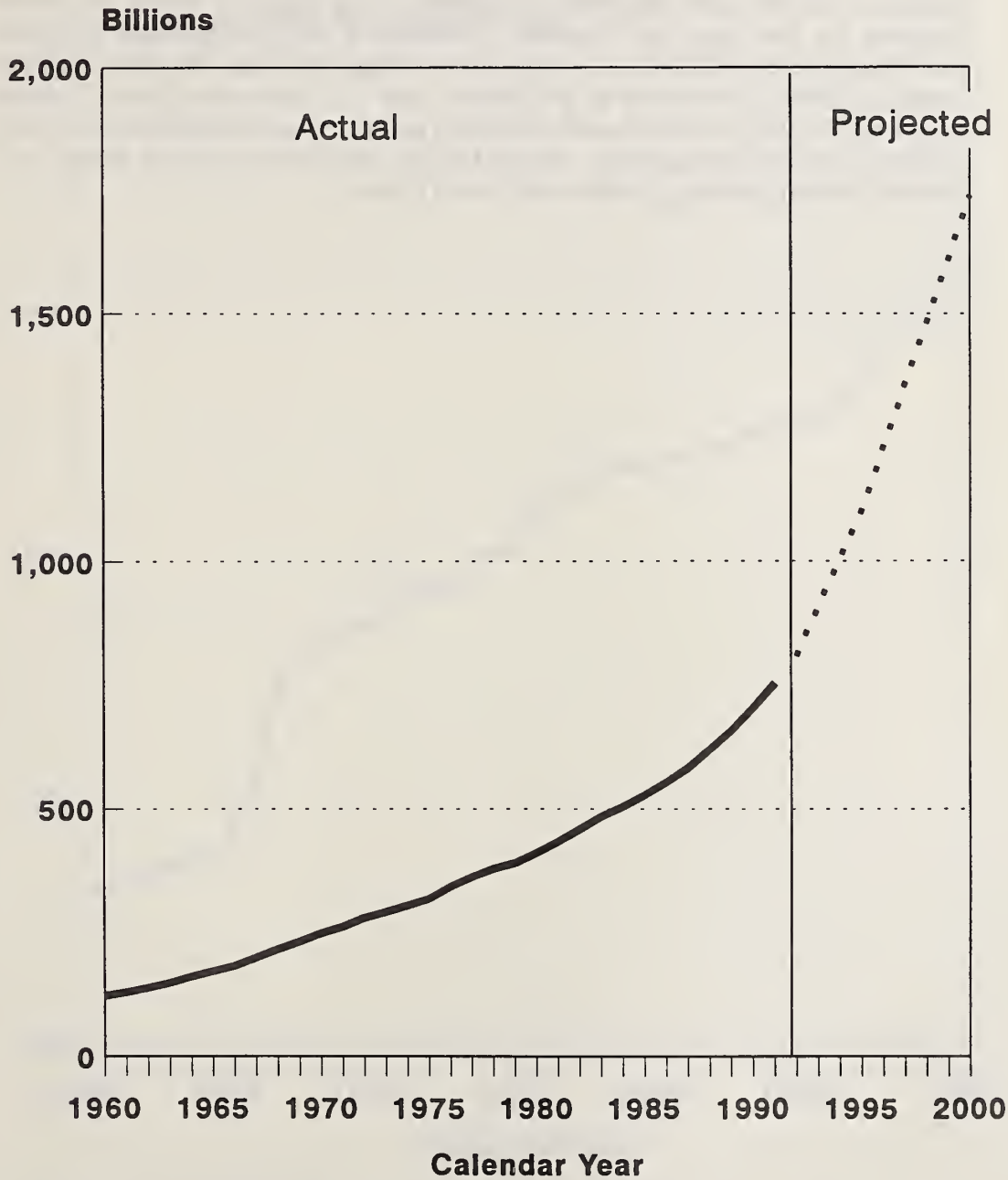


Source: Figure prepared by CRS based on data from the National Health Expenditure Series, Office of the Actuary, Health Care Financing Administration

Figure 3. Actual and Projected National Health Expenditures, 1960 - 2000

National health expenditures rose at an annual average rate of 11.3 percent from 1960 through 1991. From 1985 through 1991 spending grew an average of 10.1 percent a year. Based on recent Health Care Financing Administration projections, health care spending is expected to grow to $1.7 trillion by the year 2000. This represents an average annual growth rate of 10.1 percent between 1990 and the end of the century.

Figure 3: Actual and Projected Health Expenditures, 1960 to 2000

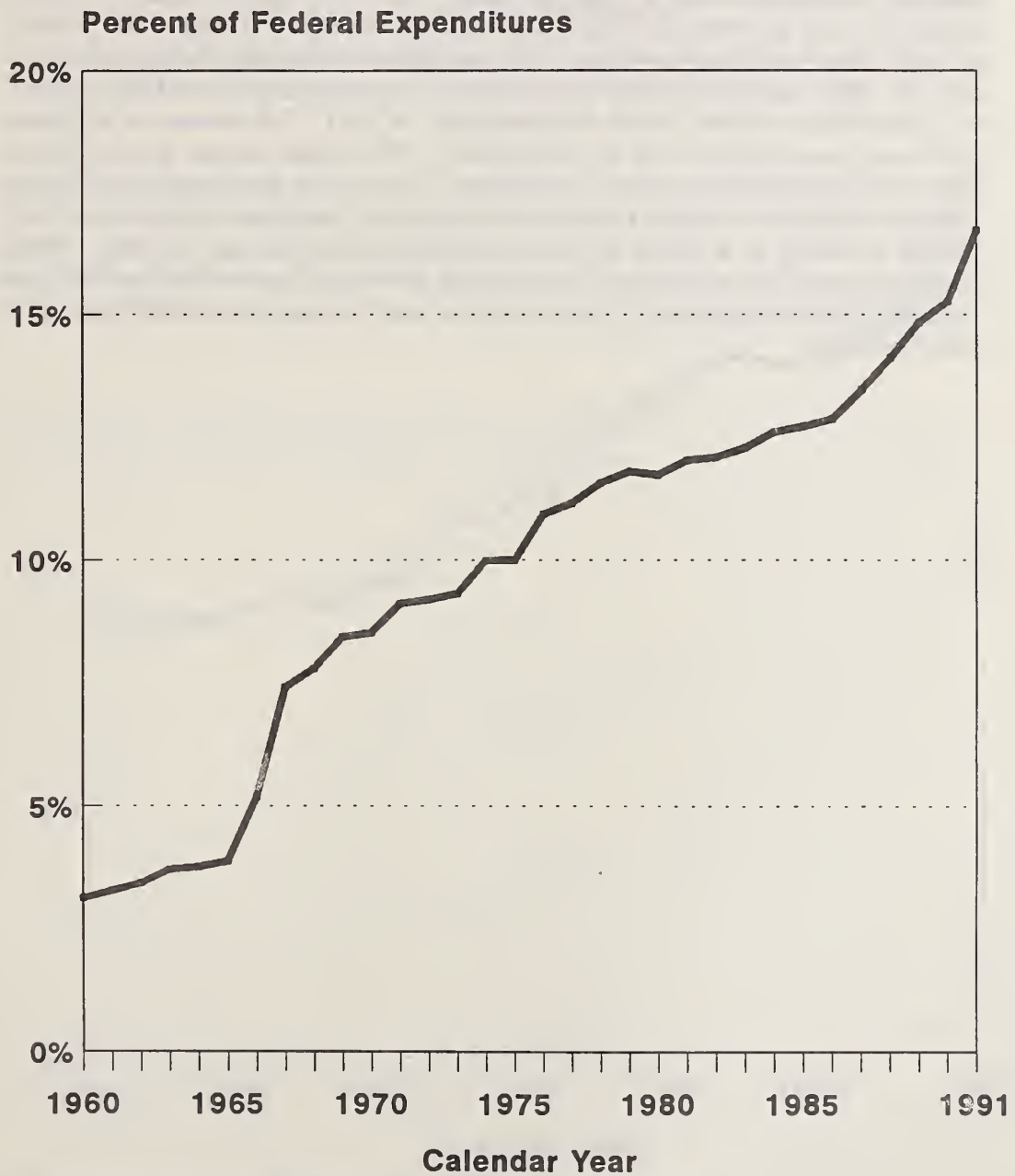


Source: Figure prepared by CRS, based on National Health Expenditure data, and Health Care Financing Administration Projections

Figure 4. Federal Health Spending as a Share of Federal Expenditures, 1960 - 1991

In 1960, Federal health expenditures were $2.9 billion or 3.1 percent of total Federal expenditures. Federal health spending and its share of the Federal budget changed dramatically beginning in 1966 following the enactment of the Medicare and Medicaid programs. Medicare is the Nation's health insurance program for the aged and disabled. Medicaid is the Federal-State program providing medical assistance to certain low-income persons. By 1980, Federal health spending amounted to $72 billion and 11.7 percent of total Federal spending. In 1991, Federal health spending had increase to $223 billion, or 16.7 percent of all Federal spending. Federal health spending has grown faster than overall Federal spending in 30 of the last 31 years.

Figure 4: Federal Health Spending as a Share of Federal Expenditures, 1960 to 1991

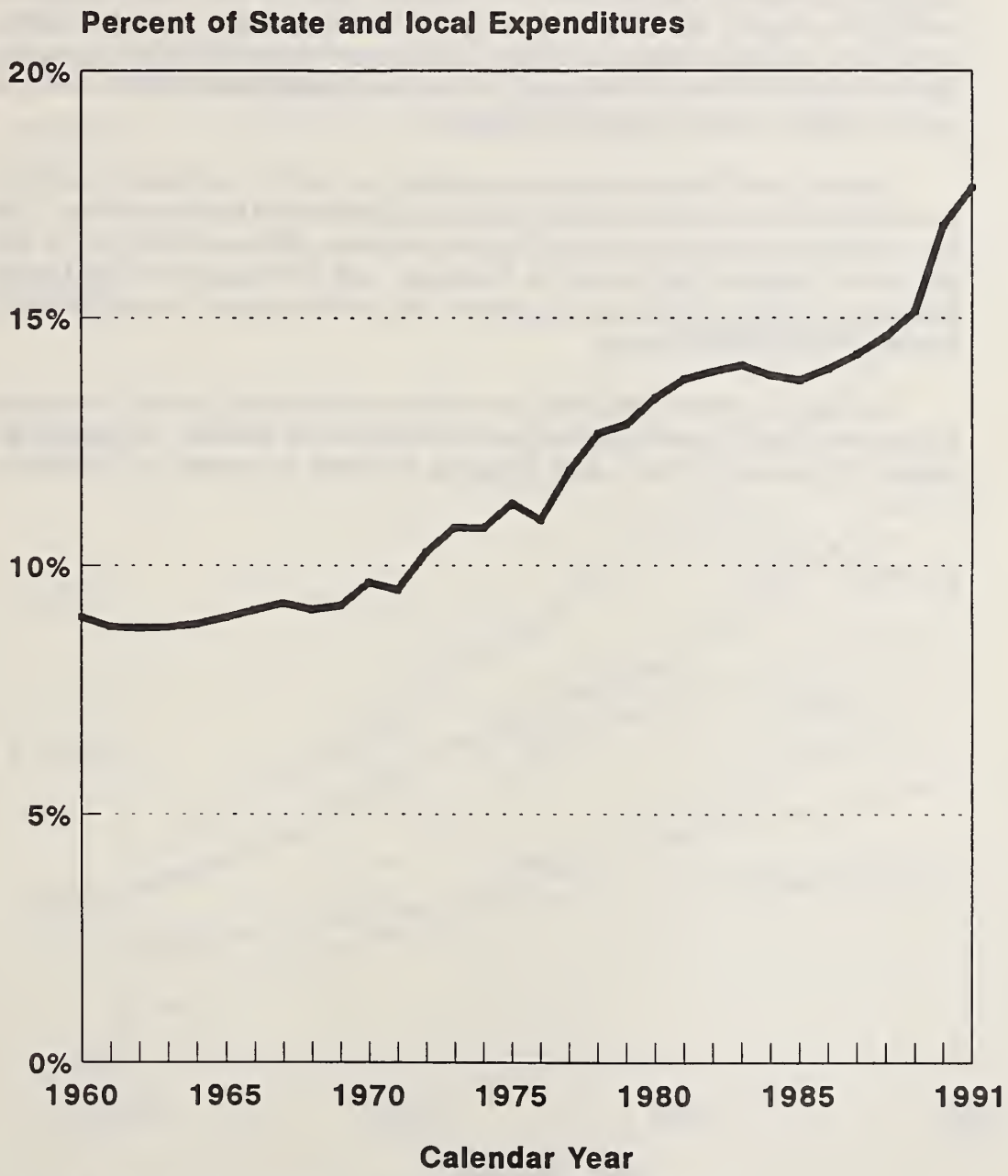


Source: Figure prepared by CRS, based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration

Figure 5. State and Local Health Spending as a Share of State and Local Expenditures, 1960-1991

The trend in State and local health spending is similar to that for Federal health spending, but not as pronounced. State and local health spending has been an increasing share of State budgets in 23 of the last 31 years. In 1960, State and local government health expenditures were $3.7 billion or 9.0 percent of total State and local government expenditures (excluding Federal grant-in-aid). In 1980, health spending by State and local governments was $33.2 billion, or 13.8 percent of State and local spending. In 1991, 17.6 percent of all State and local expenditures were for health care. The single largest component of State and local health spending is Medicaid. Increasing spending by the States for their Medicaid programs explains the dramatic increase in State and local health spending as a share of total spending during the last 2 years. State Medicaid spending has increased during this period as the result of medical care inflation, greater numbers of eligible people, and changes in provider payments and financing.

Figure 5: State and Local Health Spending as a Share of State Expenditures, 1960 to 1991



Note: State & local expenditures net of Federal grants in aid.
Source: Figure prepared by CRS, based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration

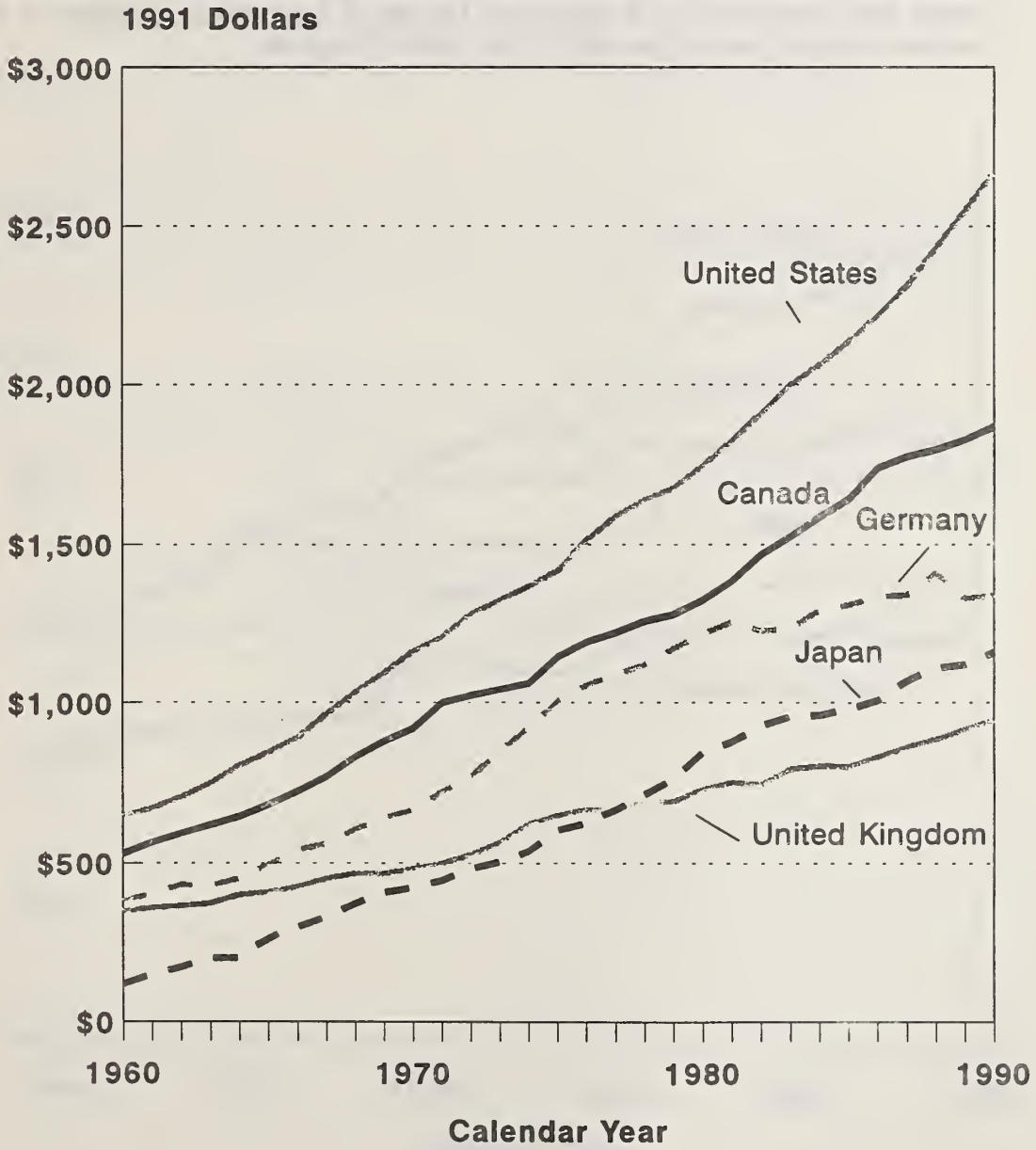
Figure 6. Real Per Capita Expenditures, United States and Selected Countries, 1960-1990

From 1960 through 1990, real per capita spending on health care in the United States was consistently higher than in other countries. In 1960, real per capita spending on health care was $648 (in 1990 constant dollars) in the U.S., compared to $530 in Canada, $381 in Germany, $349 in the United Kingdom, and $118 in Japan. By 1990, real per capita spending had increased to $2671 in the U.S. This was 43 percent higher than Canada's level of $1,869 per capita; almost double the level in Germany; 130 percent higher than Japan's, and 182 percent higher than the United Kingdom's.

Despite the differential between spending in the U.S. and other countries, the rate of growth in health spending has been substantial in all countries. U.S. per capita real spending rose by 312 percent between 1960 and 1990, and by 253 percent in Canada, 252 percent in Germany, and 171 percent in the United Kingdom. Japan's real per capita growth rate of 882 percent was significantly higher for the 30-year period.

During the period 1980-1990, per capita real spending growth was again highest for the U.S. at 53 percent, and 41 percent for Canada, 37 percent for Japan, 29 percent for the United Kingdom, and only 10 percent for Germany.

Figure 6: Real Per Capita Health Expenditures, United States and Selected Countries 1960-1990

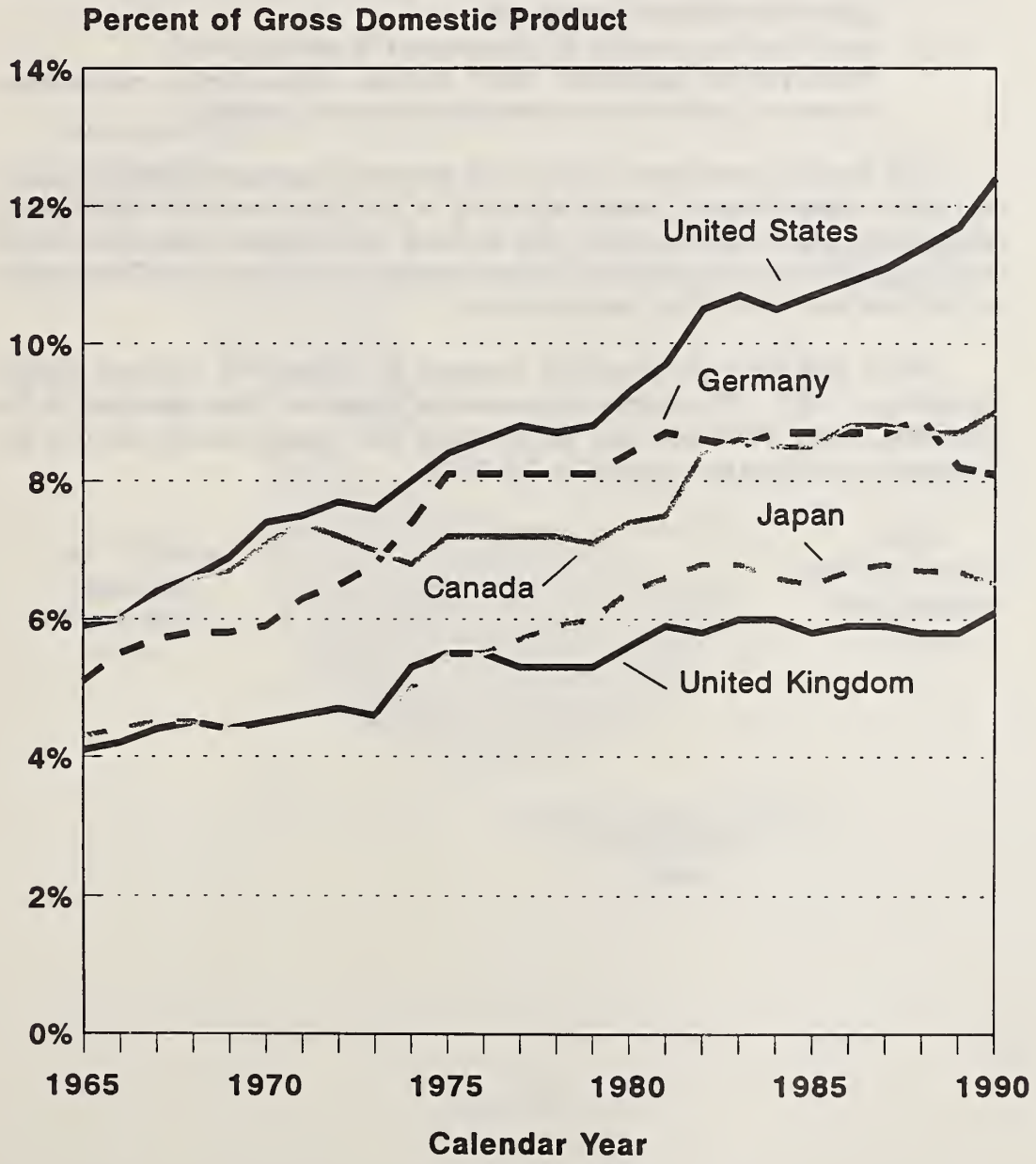


Source: Figure prepared by CRS, based on Organization for Economic Cooperation and Development, Health Data File, 1991

Figure 7. Health Expenditures as a Percentage of Gross Domestic Product, United States and Selected Countries, 1965-1990

In 1965, the United States spent 5.9 percent of its gross domestic product (GDP) on health care, compared to 6.0 percent in Canada, 5.1 percent in Germany, 4.3 percent in Japan, and 4.1 percent in the United Kingdom. Since that time, U.S. health spending, as a percent of GDP, has grown faster than in these other countries. By 1990, the U.S. spent 12.2 percent of its GDP on health care, compared to 9.0 percent in Canada, 8.1 percent in Germany, 6.5 percent in Japan, and 6.1 percent in the United Kingdom.

Figure 7: Health Expenditures as a Percentage of Gross Domestic Product, United States and Selected Countries, 1965-1990



Source: Figure prepared by CRS, based on Organization for Economic Cooperation and Development, Health Data File, 1991

Figure 8. National Health Spending, by Type of Payer, 1991

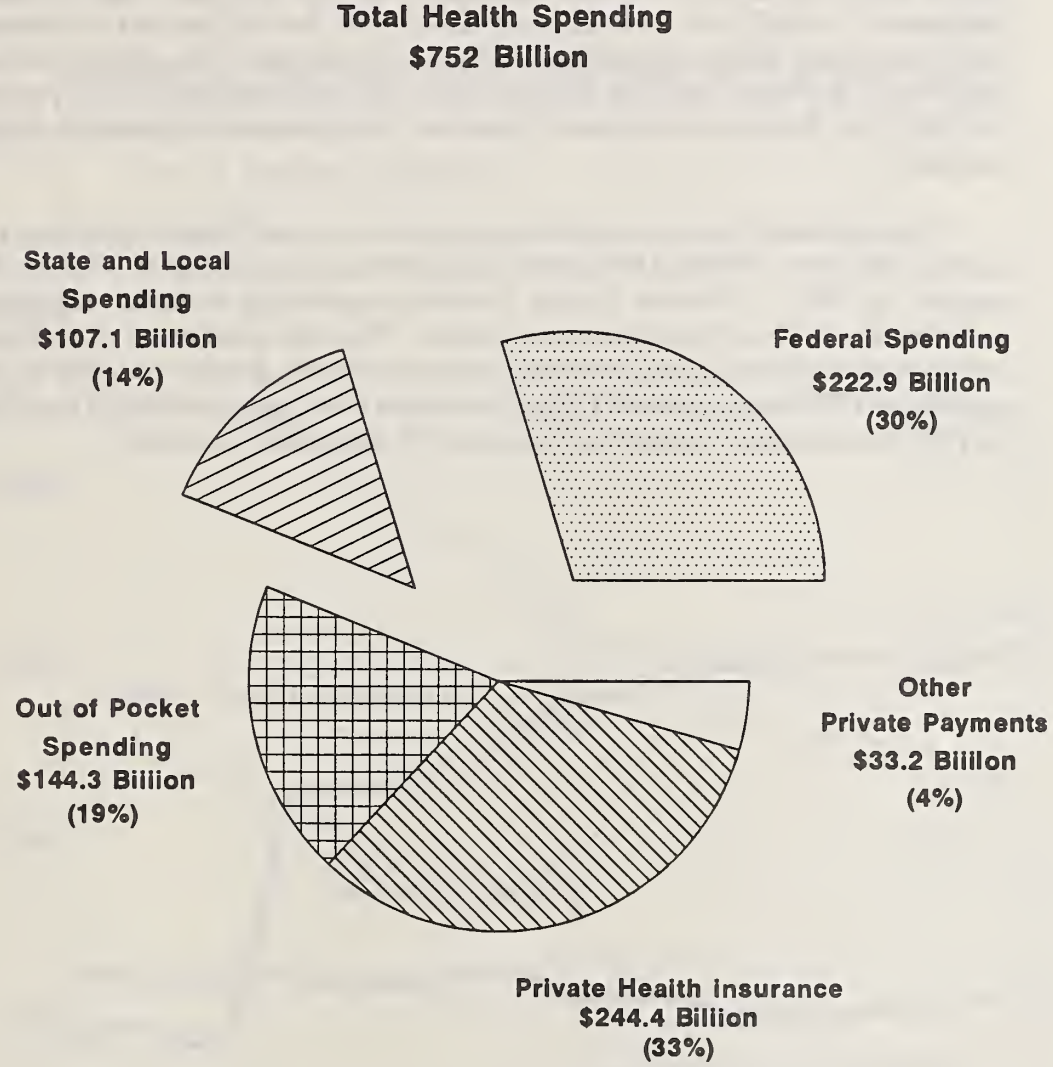
In 1991, private sector payments accounted for 56 percent of national health expenditures. Private sector payments consist of:

- private health insurance payments, which include spending by business for health insurance premiums and consumer spending for private health insurance premiums, which are typically incurred as payroll deductions (33 percent);
- out-of-pocket spending by consumers (19 percent); and
- other private payments, which includes philanthropy, non-patient sources of revenue and investment income (4 percent).

The Federal government financed 30 percent of national health spending in 1991. Most Federal health spending is for Medicare, but the Federal government also finances health care in many other forms, such as Medicaid, health care provided through the Veterans Administration and the Department of Defense, and the Public Health Service.

State and local governments financed 14 percent of national health spending in 1991. The largest component of State and local spending is for Medicaid; many State and local governments also finance health services for indigent individuals not eligible for Medicaid.

Figure 8: National Health Spending, by Type of Payer, 1991



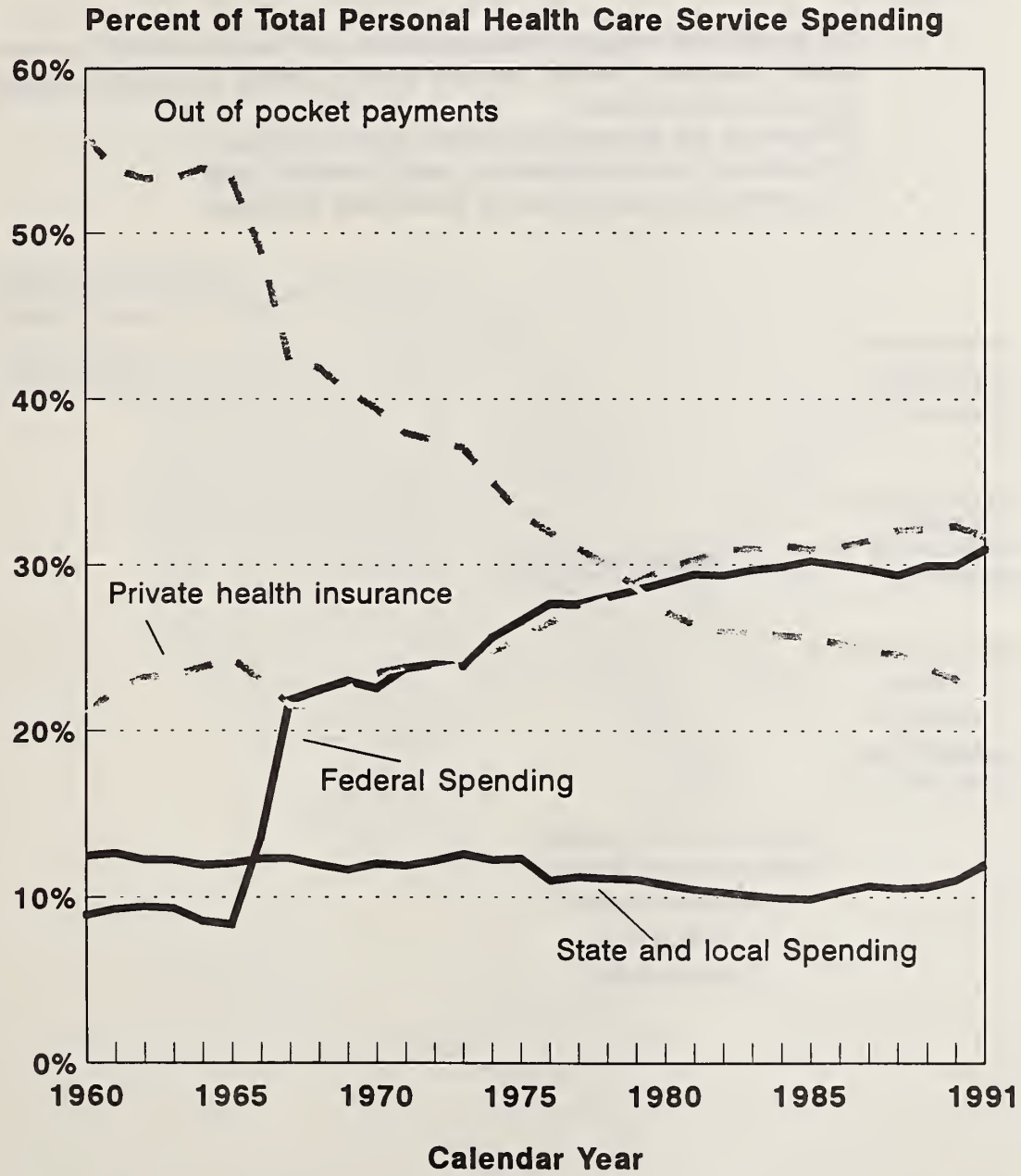
Source: Figure prepared by CRS based on National Expenditure data, Office of the Actuary, Health Care Financing Administration

Figure 9. Distribution of Health Spending by Payer, 1960 - 1991

The sources of payment for health care have changed substantially since 1960. This partly stems from increased Federal government involvement in the health sector in 1965 with the enactment of the Medicare and Medicaid programs. In 1965, the Federal government paid for 8.3 percent of personal health spending. Federal spending continued to rise until 1985, when it reached 30 percent. Between 1985 and 1990, its share has fluctuated around 30 percent. In 1991, the Federal government paid for 30.9 percent of personal health spending.

Private health insurance spending's share of overall health spending rose moderately from 1965 to 1991, from 24.3 percent of spending in 1965 to 31.7 percent in 1991. Private health insurance spending includes employee's contribution to health insurance premiums. With the enactment of Medicare, out-of-pocket spending by consumers declined from 56 percent in 1960 to 39.5 percent in 1970 and continued falling as a share of all personal health spending. In 1991, out-of-pocket spending comprised 22 percent of the total.

Figure 9: Selected Sources of Payment for Personal Health Care Services, 1960 to 1991



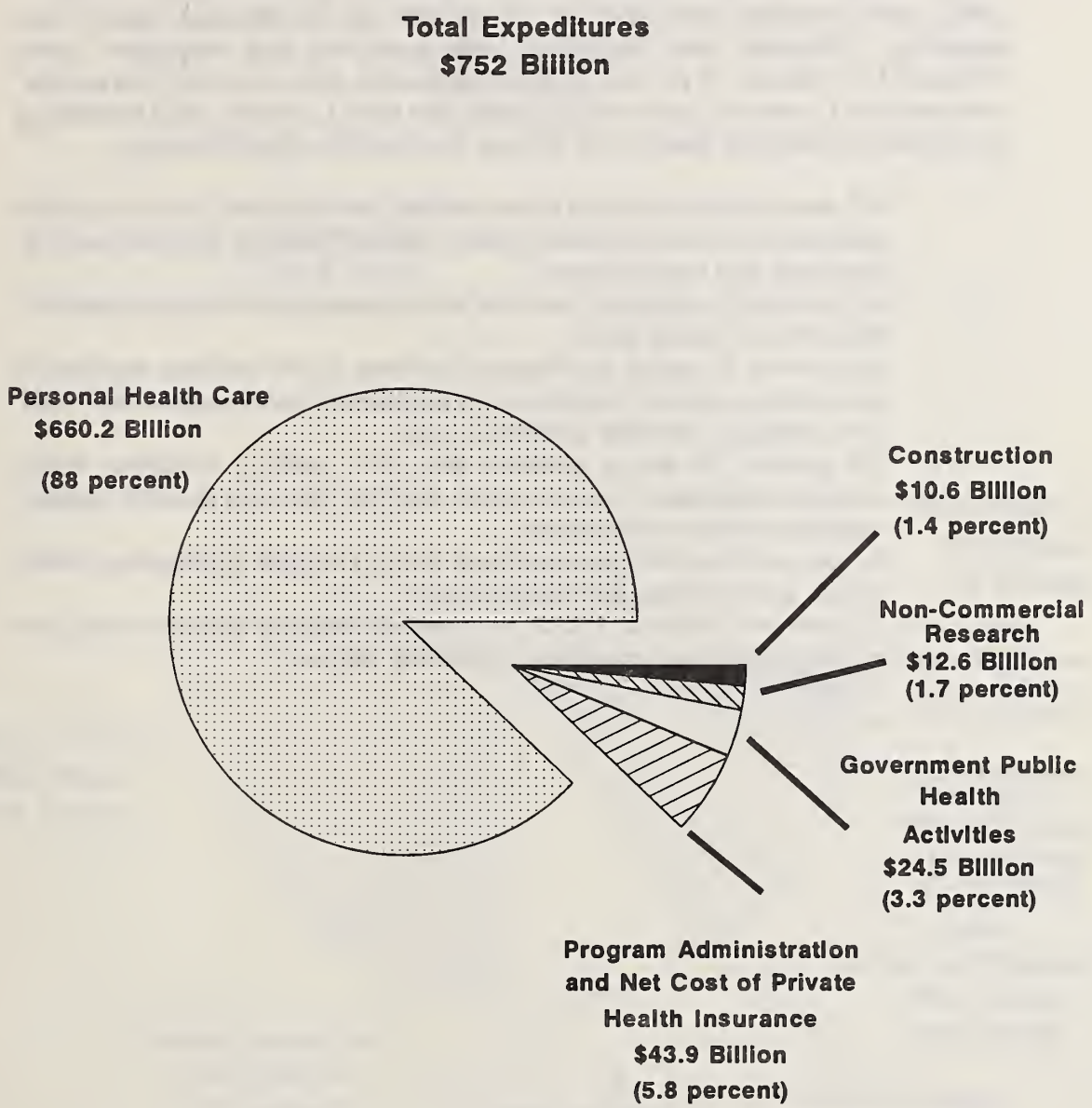
Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

Figure 10. National Health Expenditures, by Type of Expenditure, 1991

Most health care spending is for personal health care services provided to individuals. In 1991, personal health care spending accounted for 88 percent of total national health expenditures. The remaining 12 percent was spent for the following:

- 5.8 percent for program administration and the net cost of private health insurance (which includes profits earned by private health insurance companies);
- 3.3 percent for government public health activities;
- 1.7 percent for non-commercial health research; and
- 1.4 percent for construction of health care facilities.

Figure 10: National Health Expenditures, by Type of Expenditure, 1991



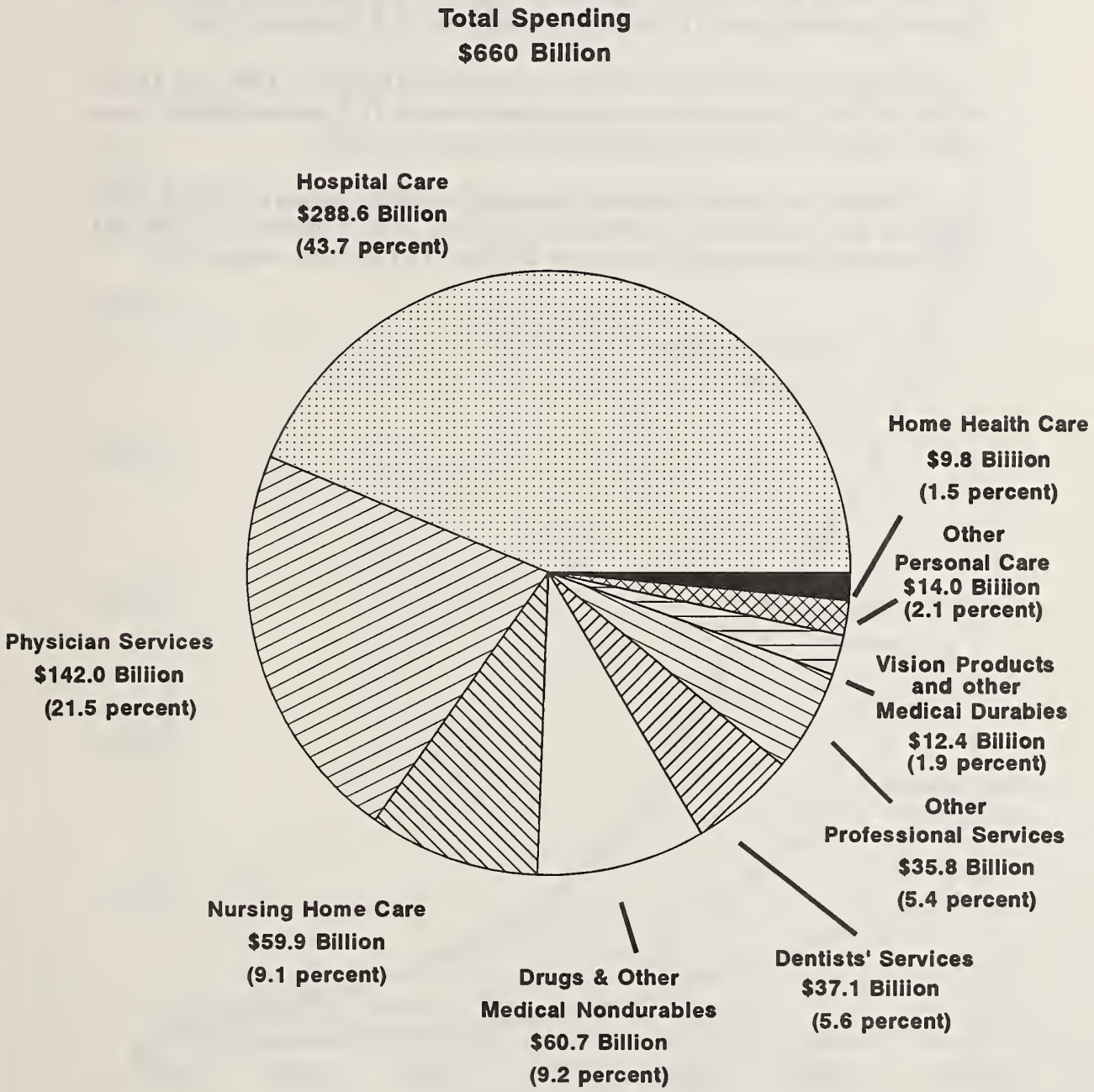
Source: Figure prepared by Congressional Research Service, based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration

Figure 11. Personal Health Care Spending, 1991

Three categories of health care services--hospital care, physicians' services and nursing home care--comprise the bulk of personal health care spending. In 1991, these services accounted for 74 percent of all personal health care spending. Hospital care (including both inpatient and outpatient care) accounted for almost 44 percent of personal health care spending, physicians' services for 21.5 percent, and nursing home care for 9.1 percent. The remaining 26 percent of personal health care dollars was used for the following:

- 9.2 percent for drugs and other medical non-durables, which includes prescription and non-prescription drugs and medical supplies such as bandages and heating pads;
- 5.6 percent for dentists' services, which includes services rendered by dentists and dental labs;
- 5.4 percent for other professional services, which includes services of private duty nurses, chiropractors, podiatrists, optometrists and other non-physician provider health services;
- 1.9 percent for vision products and other medical durables, which includes eyeglasses, contact lenses, hearing aids, and durable medical supplies such as wheelchairs;
- 2.1 percent for other personal care, which includes employer-provided health care services and facilities; and
- 1.5 percent for home health care, which includes skilled nursing or other medical care provided in patients' homes.

Figure 11: Personal Health Care Spending, by Service Category, 1991



Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

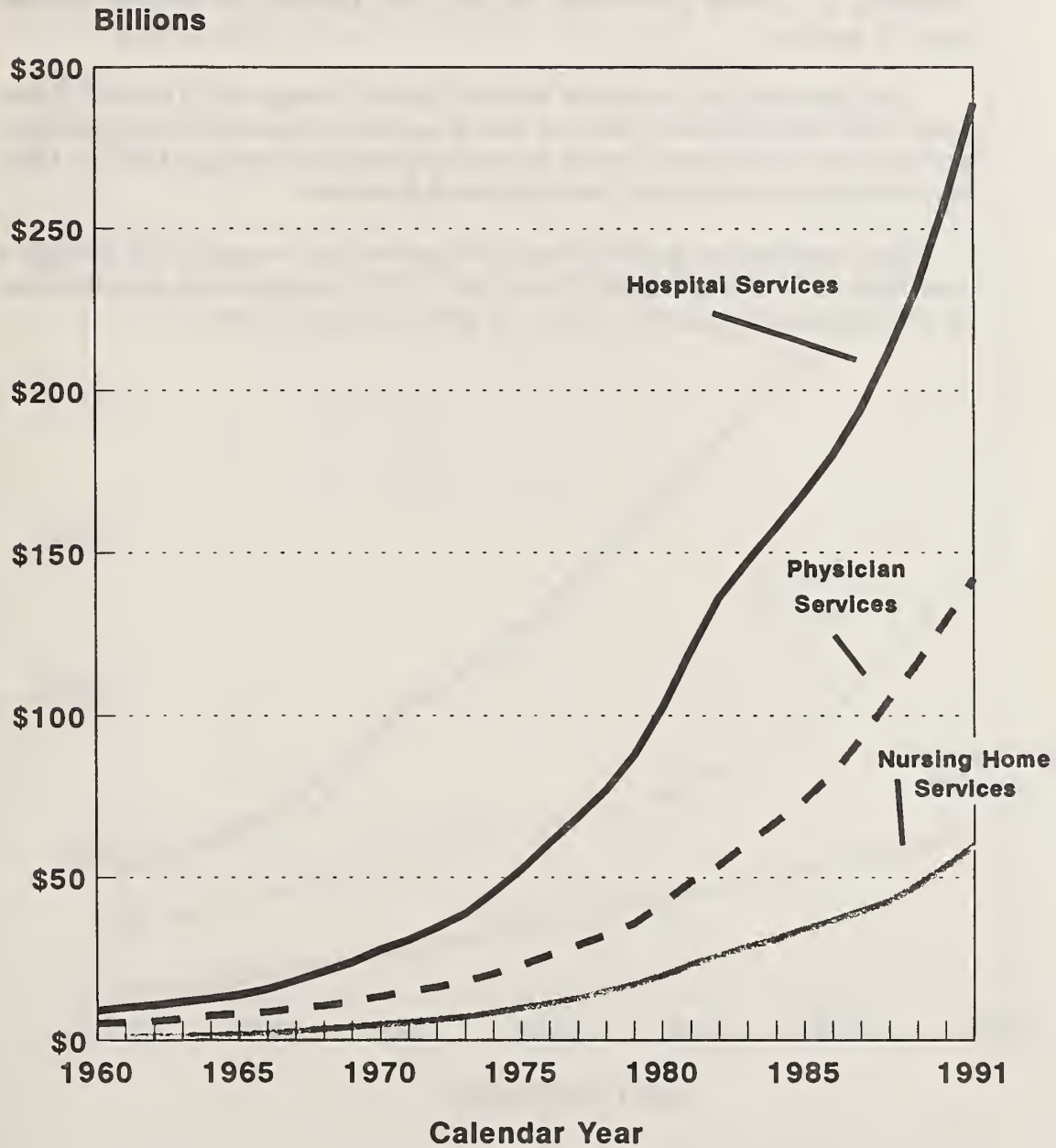
Figure 12. Spending Trends for Inpatient and Outpatient Hospital, Physician and Nursing Home Services, 1960-1991

Spending on hospital care rose from $9.3 billion in 1960 to $288.6 billion in 1991, rising at an average annual rate of 11.7 percent during these years. Hospital spending grew 11.1 percent in 1990 and 11.8 percent in 1991.

Spending on physicians' services equalled $5.3 billion in 1960 and $142.0 billion in 1991, rising at an average annual rate of 11.2 percent during these years. It rose 11 percent in 1990 and 10.2 percent in 1991.

Spending on nursing home services rose from $980 million in 1960 to $59.9 billion in 1991, rising at an average annual rate of 14.2 percent. In 1990 and 1991 nursing home expenditures grew 12.3 and 12.4 percent, respectively.

Figure 12: Spending Trends for Inpatient and Outpatient Hospital, Physician and Nursing Home Services, 1960 to 1991



Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

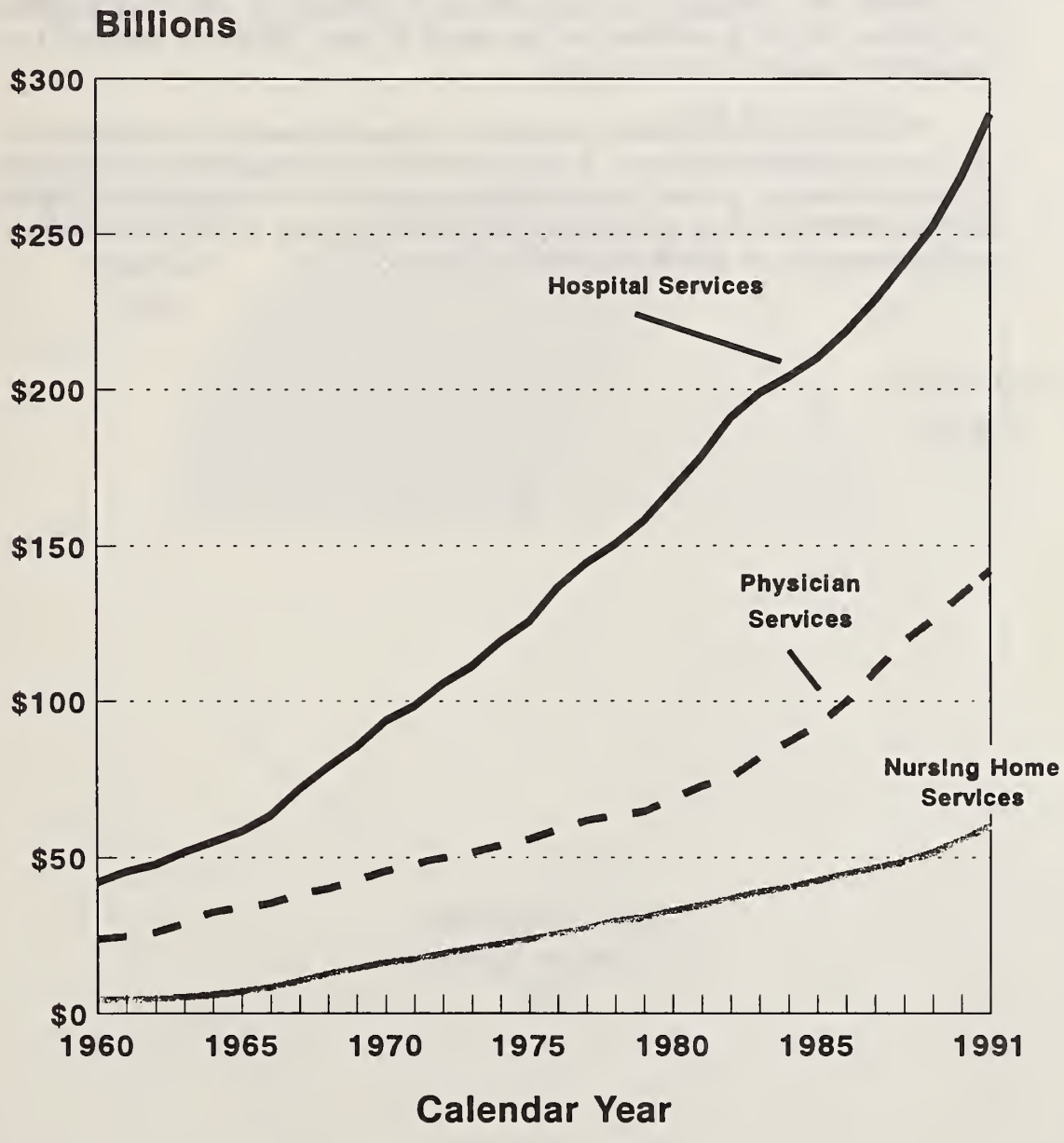
Figure 13. Spending Trends for Inpatient and Outpatient Hospital, Physician, and Nursing Home Services in Constant 1991 Dollars, 1960-1991

Real spending on hospital services rose an average of 6.4 percent a year from 1960 through 1991. From 1980 - 1985, real spending rose an average of 4.5 percent a year. However, the rate of growth has accelerated since 1985, averaging 5.4 percent per annum. In 1991, real spending on hospital services rose 7.4 percent.

Real spending on physicians' services rose an average of 5.9 percent a year from 1960 through 1991. The real rate of increase in spending for physicians' services rose at an annual rate of 7.4 percent from 1985 through 1991. In 1991, real spending for physicians' services rose 5.9 percent.

Real spending on nursing home services rose an average of 8.8 percent a year from 1960 through 1991. From 1985 - 1991, nursing home spending rose at an average of 5.9 percent a year. In 1991, it rose 8.0 percent.

Figure 13: Spending Trends for Inpatient and Outpatient Hospital, Physician and Nursing Home Services, in Constant 1991 Dollars, 1960 to 1991



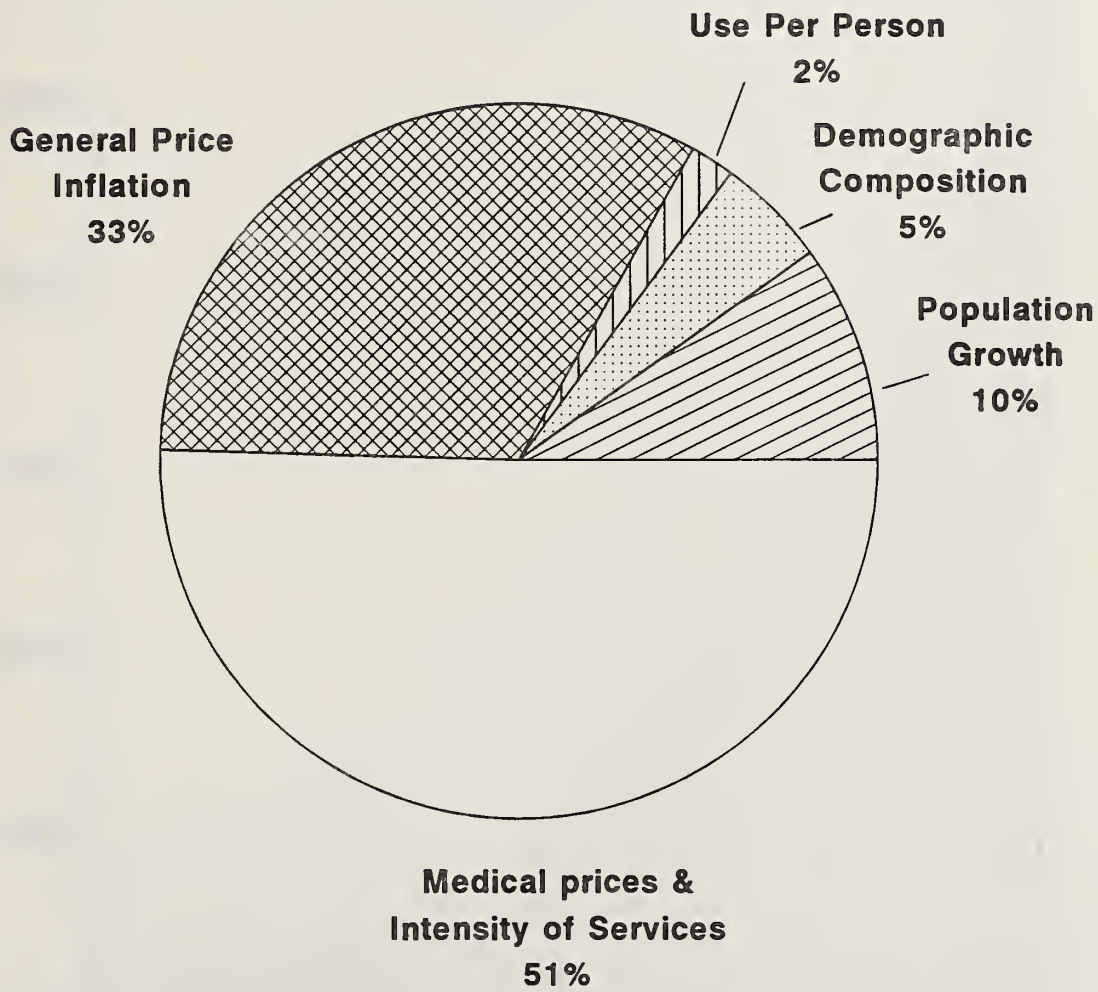
Note: Constant dollar estimates based on implicit price defiator for GDP.
Source: Figure prepared by CRS based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration

Figure 14. Factors Contributing to the 1990-1992 Increase in Health Spending

Three factors external to the health care system accounted for 48 percent of the increase in health care expenditures between 1990 and 1992. General price inflation accounted for 33 percent of the growth in health care expenditures. An increase in the size of the general population accounted for 10 percent of increased expenditures, and changes in the demographic composition of the population, as the result of such factors as aging of the population, accounted for 5 percent.

The remaining 53 percent of growth in expenditures can be attributed to factors related to medical care. Examples of these factors include medical price inflation exceeding general price inflation, changes in the intensity of health services as the result of such factors as the development of new technologies, and increased use of health services per person.

Figure 14: Factors Contributing to the 1990-1992 Increase in Personal Health Care Spending

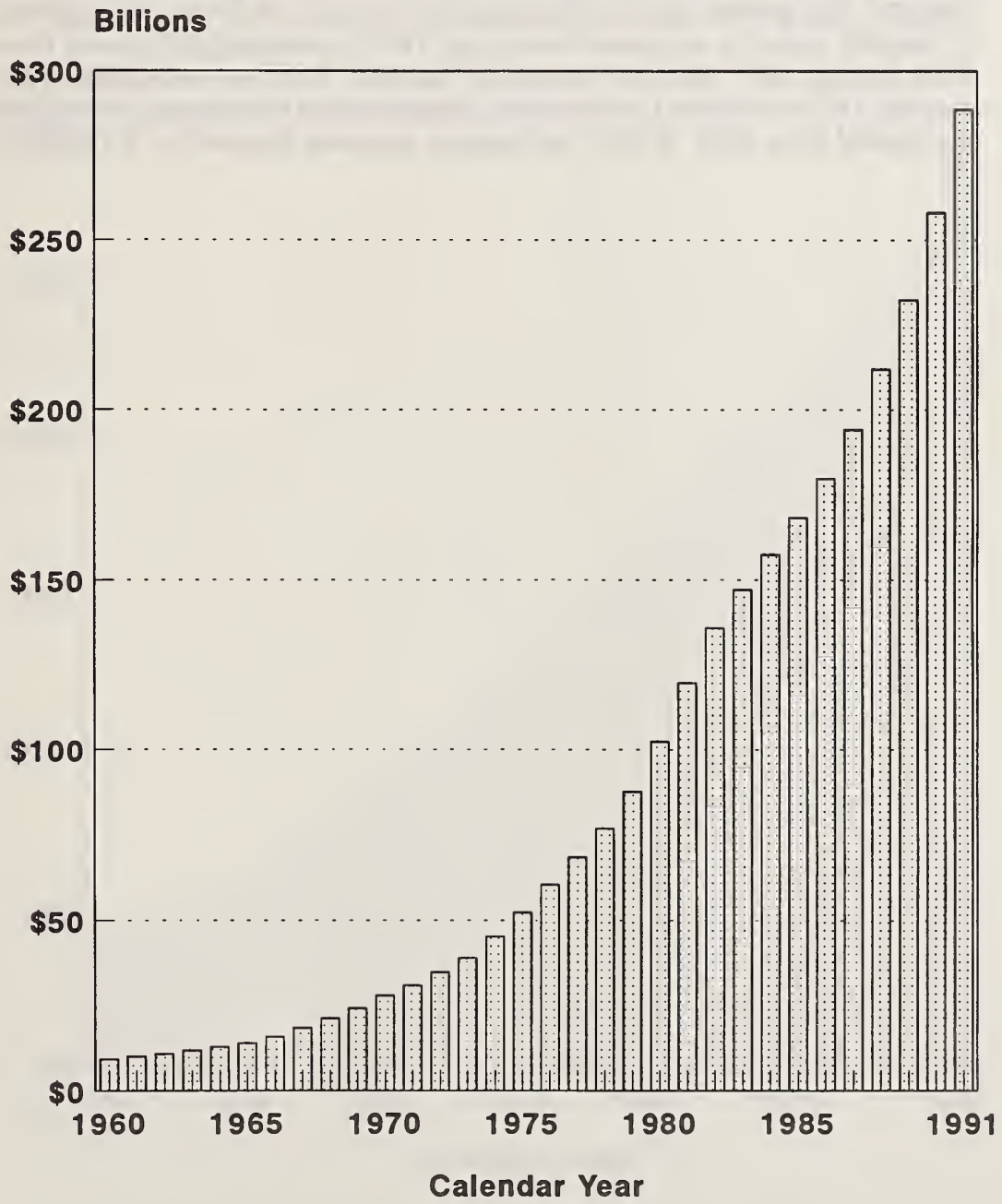


Source: Figure prepared by Congressional Research Service based on a Congressional Budget Office analysis of actual and projected health spending

Figure 15. Spending Trends for Inpatient and Outpatient Hospital Services, 1960-1991

Spending trends in hospital services include both inpatient and outpatient spending. Rates of increase in hospital spending were highest in the late 1960's, following the implementation of Medicare and Medicaid; in the mid-1970's; and in the early 1980's. During the mid-1980's (1983-1986), growth rates moderated. Since 1987, the rate of increase in hospital spending has accelerated, reaching 9.2 percent in 1988, 9.6 percent in 1989, 11.1 percent in 1990 and 11.8 percent in 1991.

Figure 15: Spending Trend for Inpatient and Outpatient Hospital Care Services, 1960 to 1991

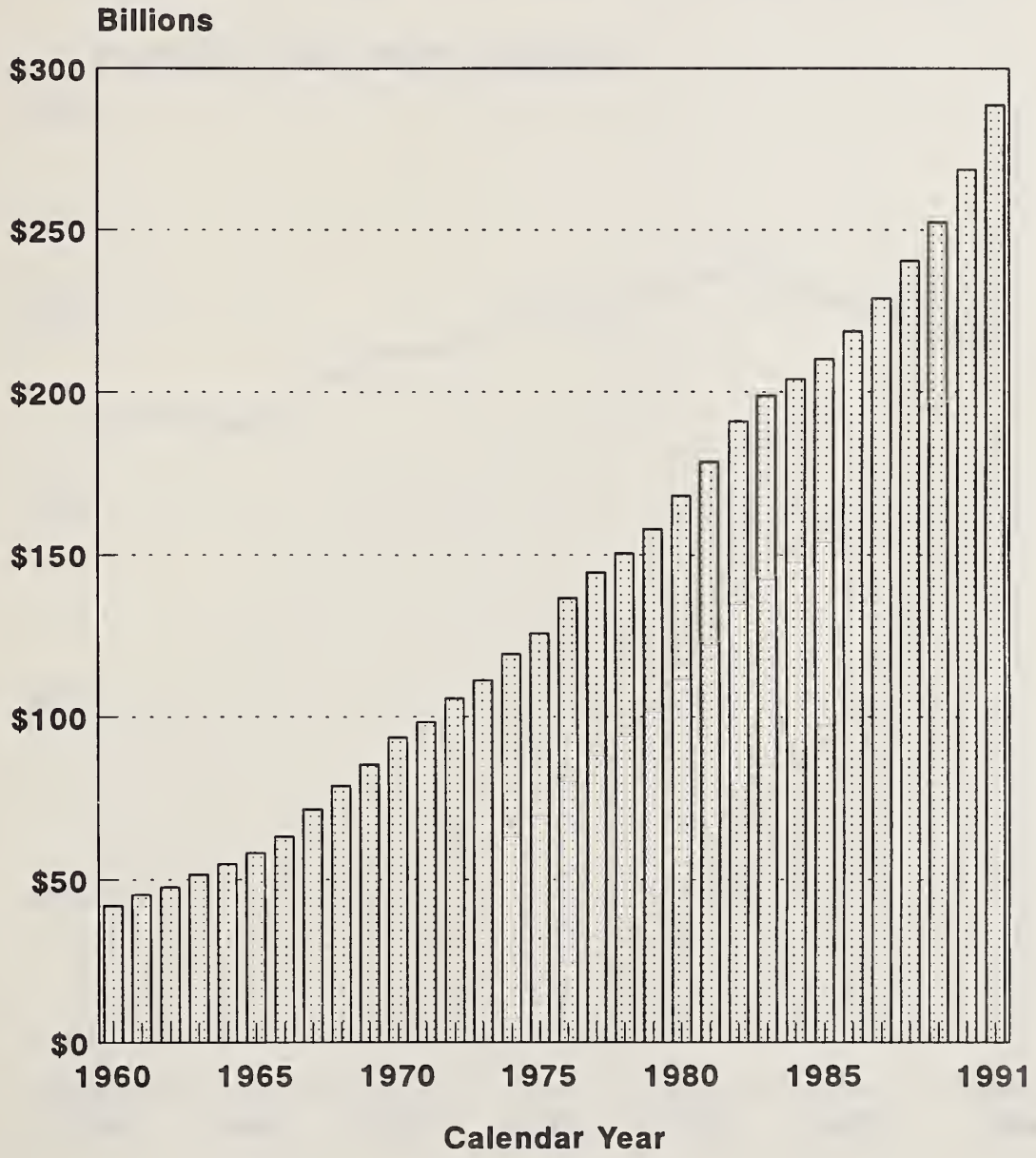


Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

Figure 16. Spending Trends for Inpatient and Outpatient Hospital Services in Constant 1991 Dollars, 1960 -1991

Spending for hospital care services has risen faster than the rate of general inflation since 1960. Real spending for hospital care rose most rapidly during the early years of Medicare and Medicaid, averaging 10.0 percent a year from 1965-70. Real growth rates were also rapid during the mid-1970's. Real growth in hospital spending moderated during the 1980's, averaging 5.0 percent from 1980 through 1991. Real growth rates of less than 5 percent a year from 1983 through 1987 contributed to this trend. Real spending for hospital services has accelerated since 1989. In 1991 real hospital spending increased by 7.4 percent.

Figure 16: Spending Trends for Inpatient and Outpatient Hospital Services, in Constant 1991 Dollars, 1960 to 1991

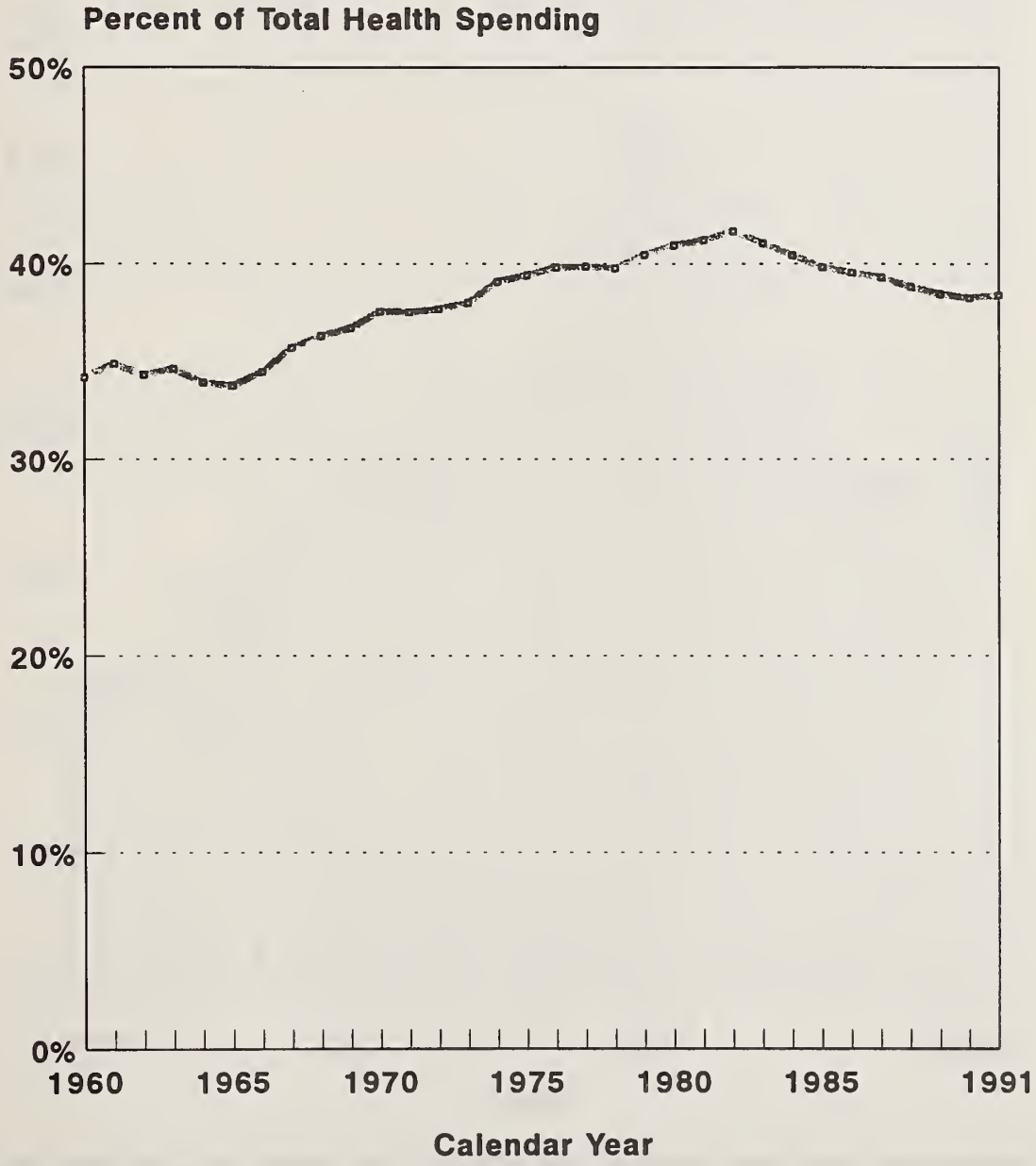


Note: Constant dollar estimates based on implicit price deflator for GDP.
Source: Figure prepared by CRS based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration

Figure 17. Spending on Inpatient and Outpatient Hospital Care as a Share of Total Health Spending, 1960-1991

Hospital spending has always represented the largest component of national health spending. In 1960, hospital spending accounted for 34 percent of all health spending. It increased gradually to 42 percent by 1982. Hospital spending declined to 38.4 percent of the total in 1991.

Figure 17: Spending on Inpatient and Outpatient Hospital Services as a Share of Total Health Spending, 1960 to 1991

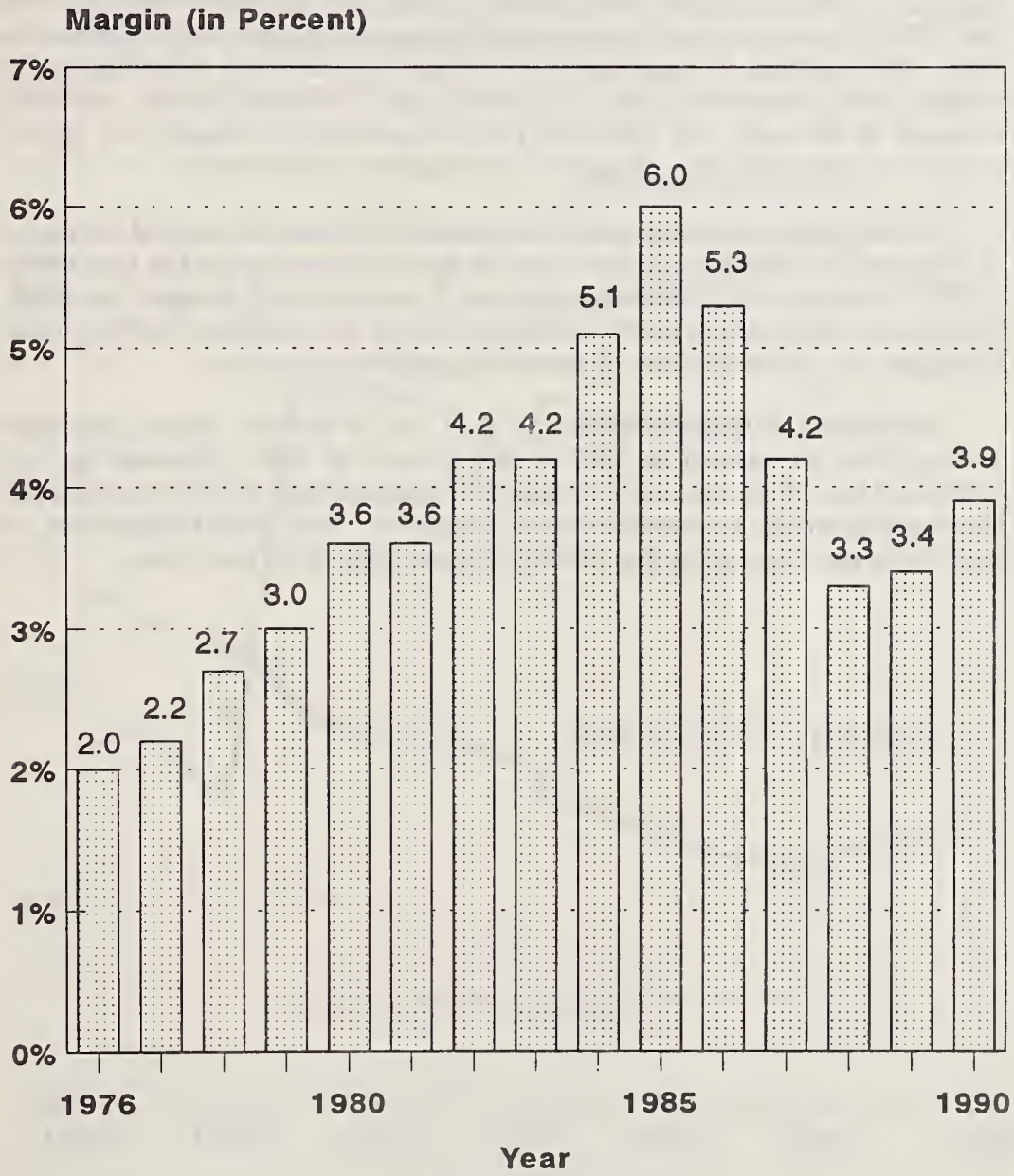


Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

Figure 18. Hospital Margins Based on Total Revenues, 1976-1990

Hospital margins are defined as the difference between revenues received by hospitals and their costs, as a percentage of revenues. Between 1976 and 1985, hospital margins rose steadily, increasing from 2 percent in 1976 to 6 percent in 1985. Since then they have declined to slightly less than 4 percent in 1990. Even with the recent decline, hospitals had a substantially higher margin in 1990 than in 1976.

Figure 18: Hospital Aggregate Total Revenue Operating Margin, 1976-1990 (in Percent)



NOTE: The total margin is defined as the ratio of total revenues minus total expenditures to total revenues.

Source: Figure prepared by CRS, based on Prospective Payment Assessment Commission analysis of American Hospital Association Annual Hospital Survey data

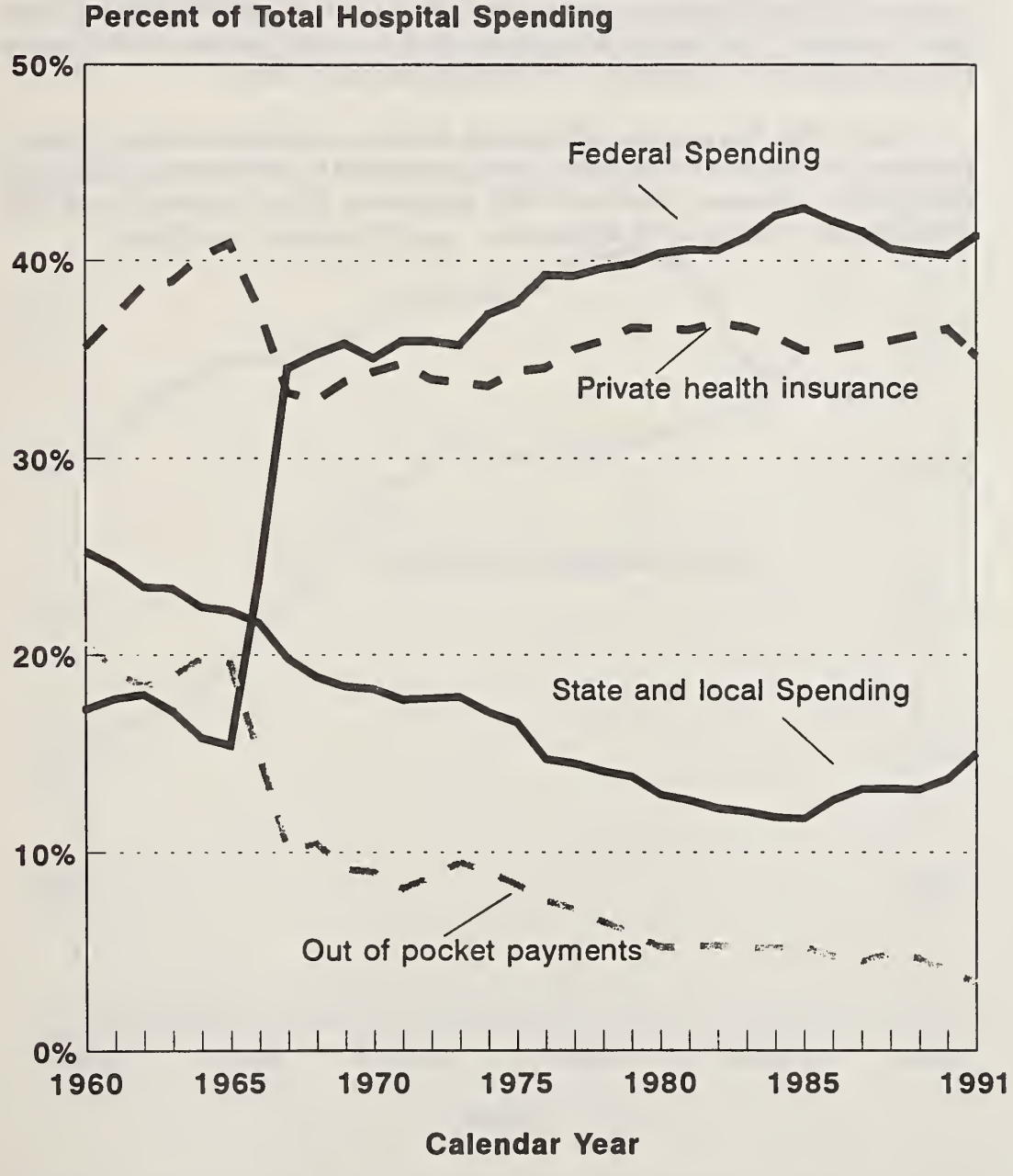
Figure 19. Selected Sources of Payment for Hospital Spending, 1960-1991

The sources of payment for hospital spending have changed significantly since 1960. Prior to the implementation of Medicare and Medicaid, the Federal government financed about 17 percent of hospital spending. The share of hospital spending paid for by the Federal government increased sharply in the late 1960's, then continued rising gradually, reaching a peak of 42.7 percent in 1985. This reflects, in large part, the elderly's higher rate of utilization of hospital care, relative to other age groups, and Medicare's nearly universal coverage of the aged. In 1991, the Federal government remains the largest payer of hospital services. It pays for 41.3 percent of the total.

Out-of-pocket spending which constituted 21 percent of hospital payments in 1960, experienced a sharp decline in its share of payments in the late 1960s. In 1970, out-of-pocket spending comprised 9 percent of all hospital spending. The share of hospital payments paid out-of-pocket by consumers has continued to decline. In 1991 the share of payments equalled 3.4 percent.

The share of hospital payments paid for by private health insurance declined from 41 percent in 1965 to 32.9 percent in 1968. Between the late 1960s and late 1970s, the share of hospital payments paid for by private health insurance gradually increased to about 35 percent. With some fluctuations, its share of hospital spending has remained around this level ever since.

Figure 19: Selected Sources of Payment for Hospital Services Spending, 1960 to 1991



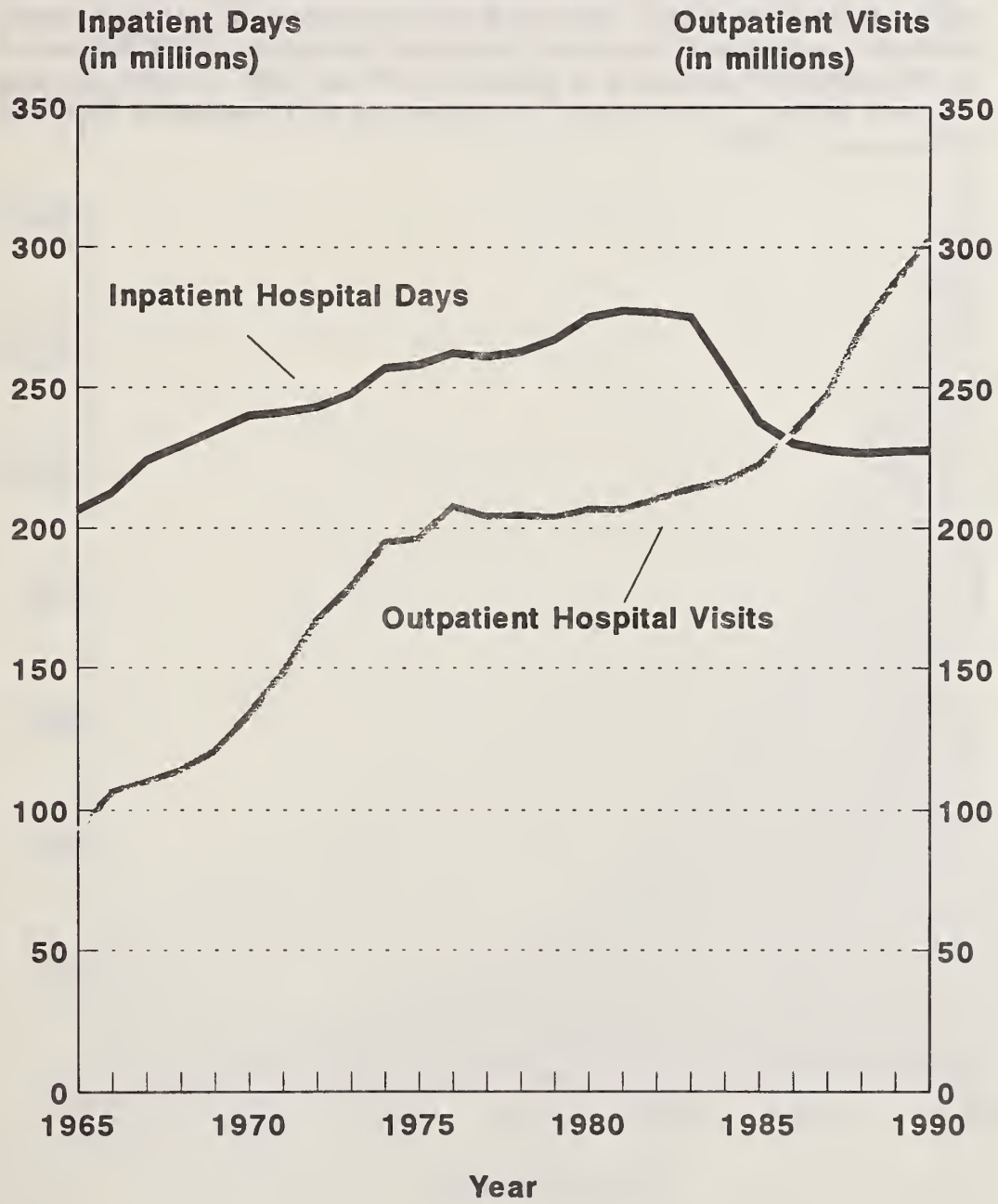
Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

Figure 20. Trends in Outpatient Visits and Inpatient Days, Short-Term General and Other Special Hospitals, 1965-1990

Between 1965 and 1975, the number of inpatient days increased from just over 200 million to almost 260 million, while the number of outpatient visits more than doubled, from less than 100 million to over 200 million. Hospital use patterns were fairly stable between 1975 and 1980. From 1981 to 1985, the number of inpatient days dropped sharply, while the number of outpatient visits grew modestly. The decline in inpatient days occurred because of declines in both the number of admissions and average lengths of stay.

Since 1985, the number of inpatient days has remained relatively stable. However, the number of outpatient visits continued to increase sharply during this period. Between 1985 and 1990, outpatient visits increased from 223 million to 303 million, or by 36 percent.

Figure 20: Trends in Outpatient Visits and Inpatient Days Short-Term General and Other Special Hospitals, 1965-90

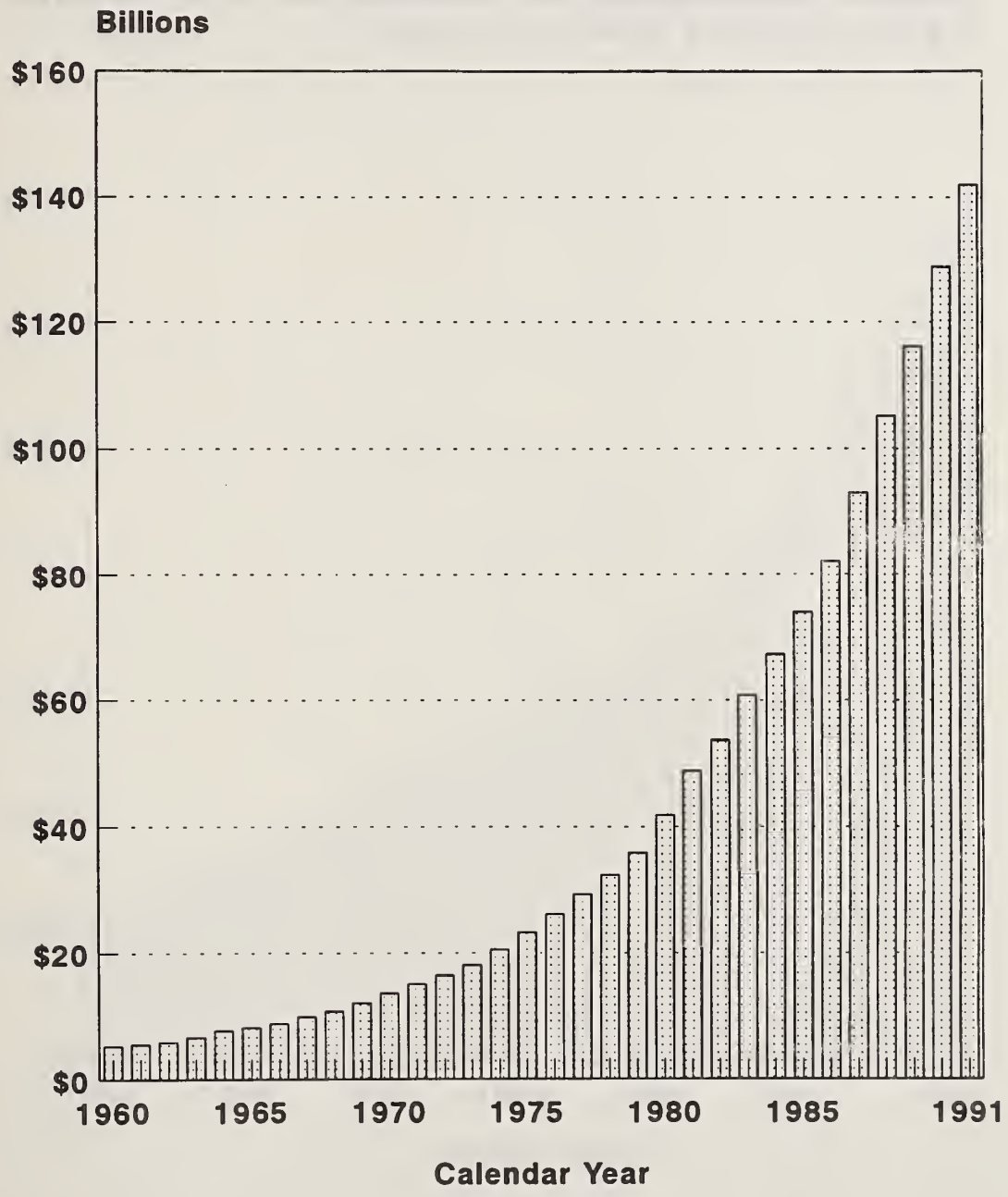


Source: Figure prepared by Congressional Research Service based on data from American Hospital Association

Figure 21. Spending Trends for Physicians' Services, 1960-1991

From 1960 through 1991, spending on physicians' services increased an average of 11.2 percent a year. In the 1980's, the rate of growth in spending was slightly faster, averaging 11.9 percent a year from 1980 to 1990. In part, the higher average rate for the 1980's reflects very high rates of growth in the early 1980's--16.5 percent in 1981. The rate of growth moderated slightly mid-decade, although it was always in excess of 10 percent. In the late 1980's, the pace of growth accelerated, exceeding 13 percent in 1987 and 1988. In 1989, the rate of growth declined to 10.4 percent, but it then rose to 11.0 percent in 1990, and 10.2 percent in 1991.

Figure 21: Spending Trend for Physician Services, 1960 to 1991

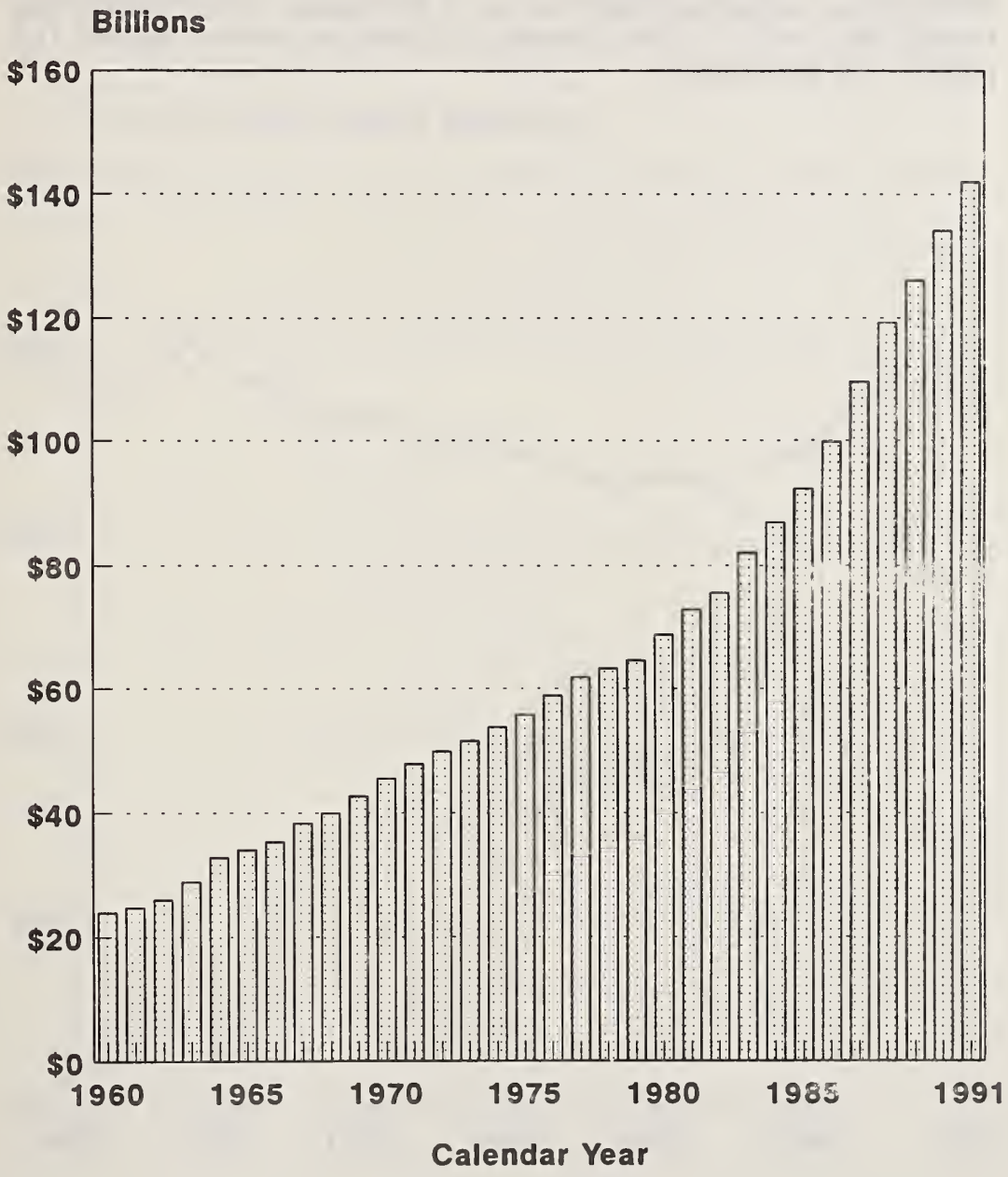


Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

Figure 22. Spending Trend for Physicians' Services in Constant 1991 Dollars, 1960-1991

Real spending for physicians' services rose an average of 5.9 percent from 1960-1991. Over the last 6 years, real physician spending increased an average of 7.4 percent per annum. This comes largely as a result of fairly rapid increases in physician spending from 1986 through 1988. In 1991, the real rate of growth in physicians' services was 5.9 percent.

Figure 22: Spending Trends for Physician Services in Constant 1991 Dollars, 1960 to 1991

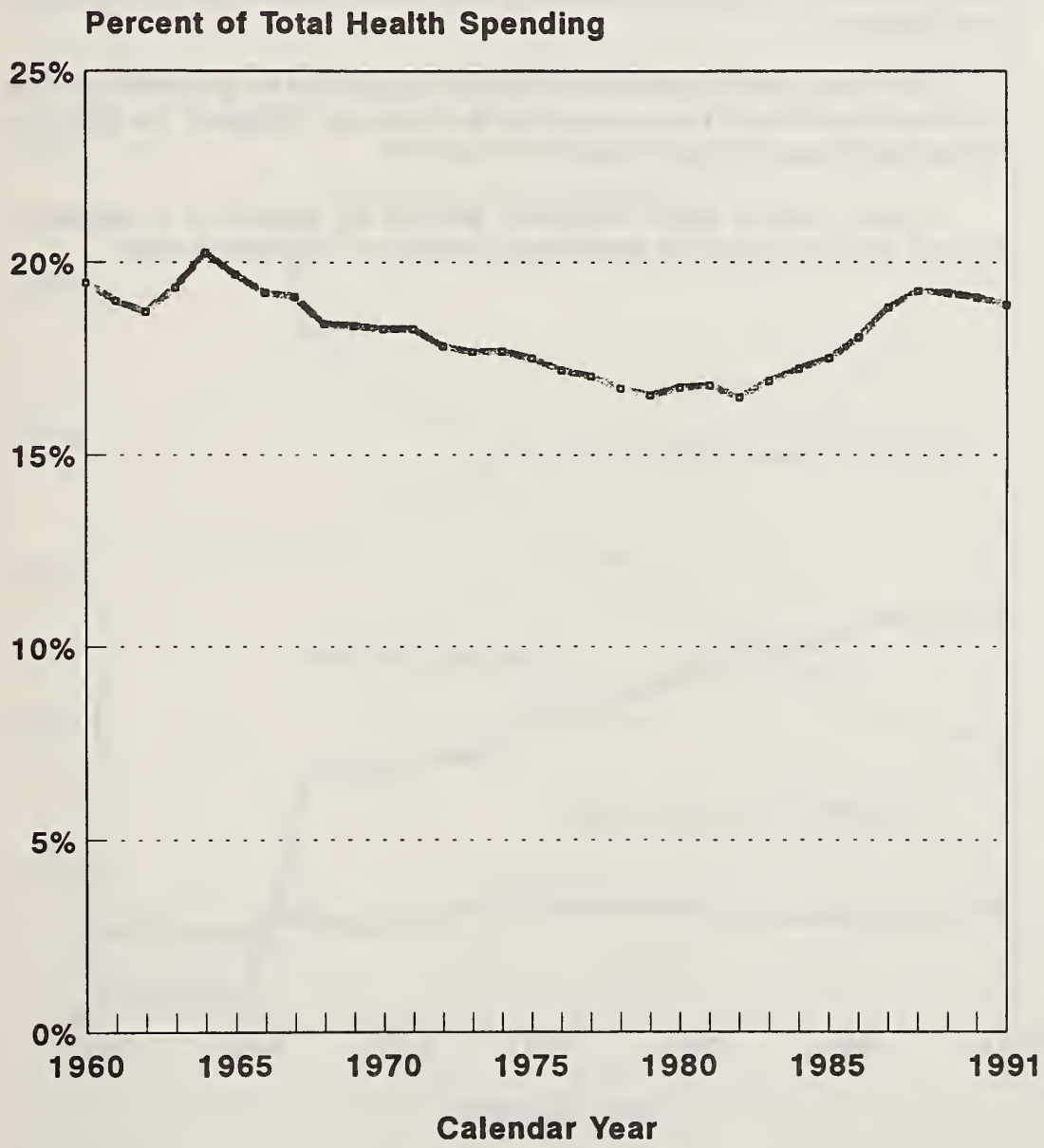


Note: Constant dollar estimates based on implicit price deflator for GDP.
Source: Figure prepared by CRS based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration

Figure 23. Spending for Physician Services as a Share of Total Health Spending, 1960-1991

In 1960, spending for physicians' services accounted for 19.5 percent of all health care expenditures. In the intervening years, the share of health spending accounted for by physicians' services has varied somewhat. Between 1967 and 1979 its share declined gradually to a low of 16.5 percent in 1979 before rising through the 1980's. In 1991, spending on physician services equalled 18.9 percent of all expenditures.

Figure 23: Spending for Physician Services as a Share of Total Health Spending, 1960 to 1991



Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

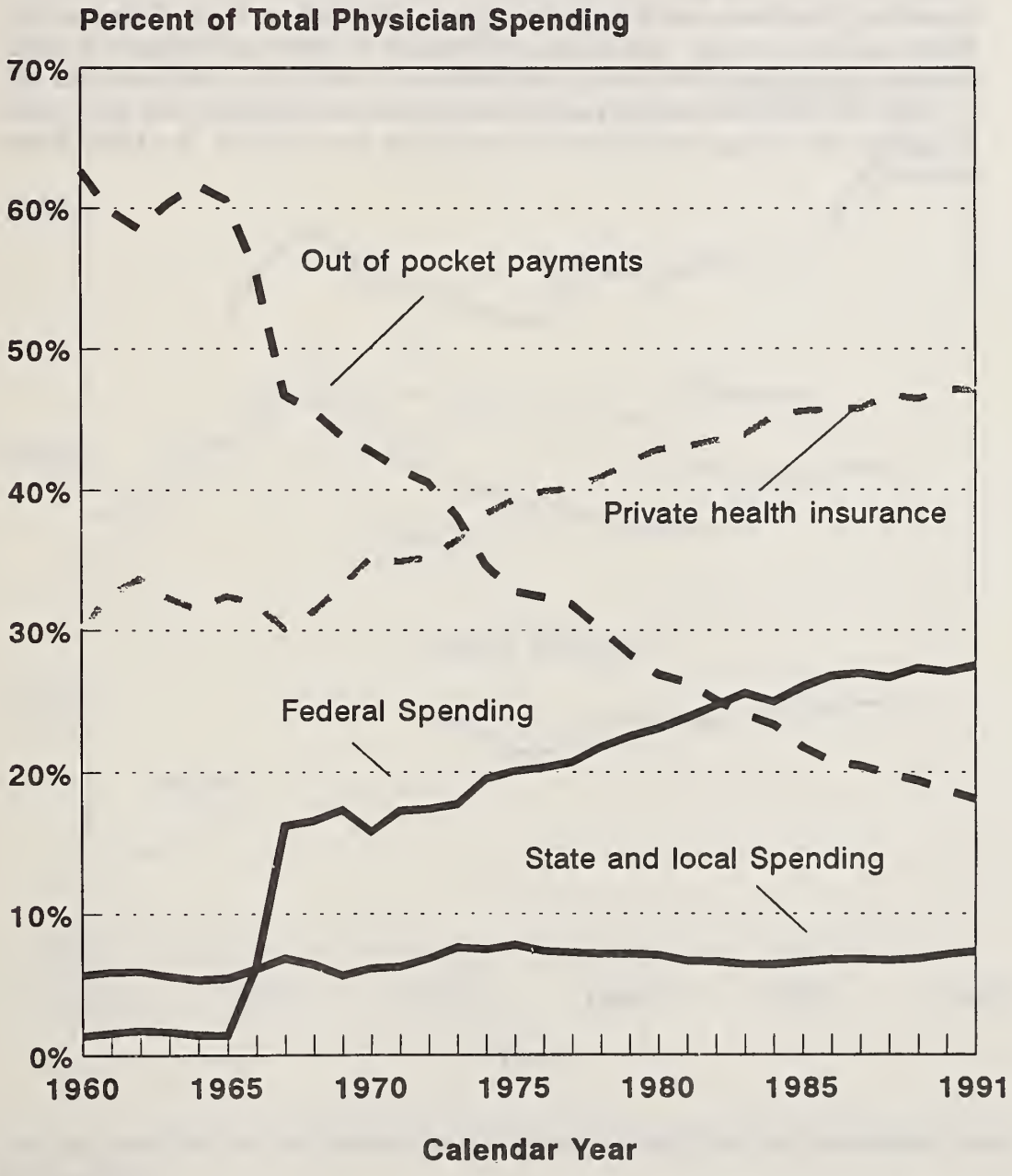
Figure 24. Selected Sources of Payment for Physician Services, 1960-1991

Since 1960 the percentage of physician services paid for by third-party payers has increased dramatically. In 1960, almost 63 percent of all physician services were paid for out-of-pocket; by 1970, out-of-pocket payments constituted 43 percent of physician services. The share has continued to declined. By 1991, only 18.1 percent of physician services payments were paid for by consumers out-of-pocket.

The Federal government's contribution to payments for physician services increased sharply with the enactment of Medicare and Medicaid. By 1991, the Federal government's share equaled 27.5 percent.

In 1960, private health insurance paid for 30 percent of all physician services, and this share has gradually increased to 47 percent in 1991.

Figure 24: Selected Sources of Payment for Physician Services, 1960 to 1991

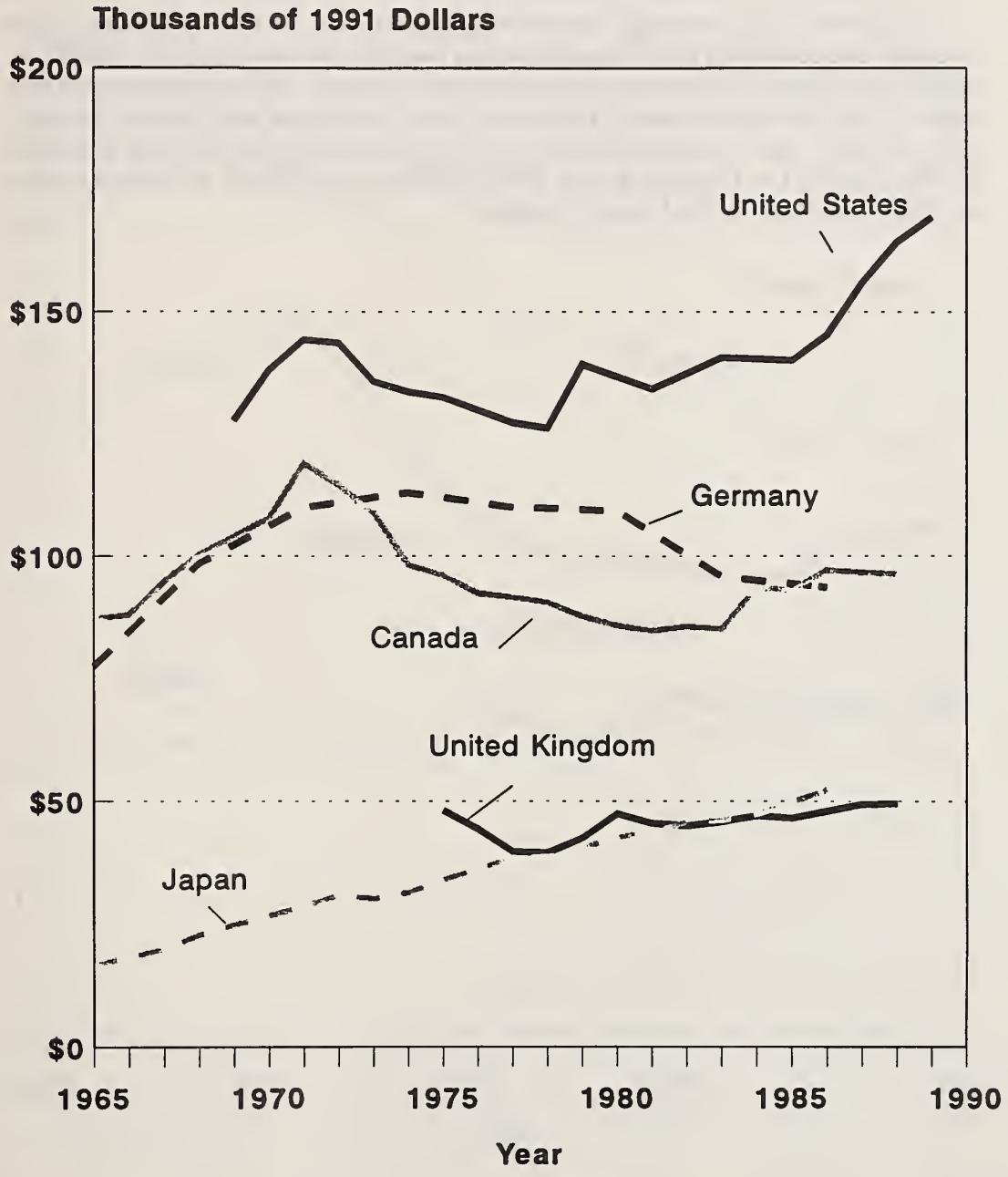


Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

Figure 25. Average Real Physician Income, Unites States and Selected Countries, 1965-1989

The average real income of physicians in the United States is higher than in other countries. In 1969, real physician income in the United States (expressed in 1991 constant dollars) was $127,722. By 1989, the real income of U.S. physicians had grown to $169,199. By comparison, the real income of Canadian physicians was $87,162 in 1965, and $96,300 in 1988. West German physicians had average real incomes of $98,433 in 1968, and $93,623 in 1986. Japanese physicians had average real incomes of $16,376 in 1965 and $52,331 in 1986. In 1975, the earliest year for which data are available from the United Kingdom, the average real income of physicians was $48,112. By 1988, it was $49,446.

Figure 25: Average Real Physician Earned Income, United States and Selected Countries, 1965 - 1989



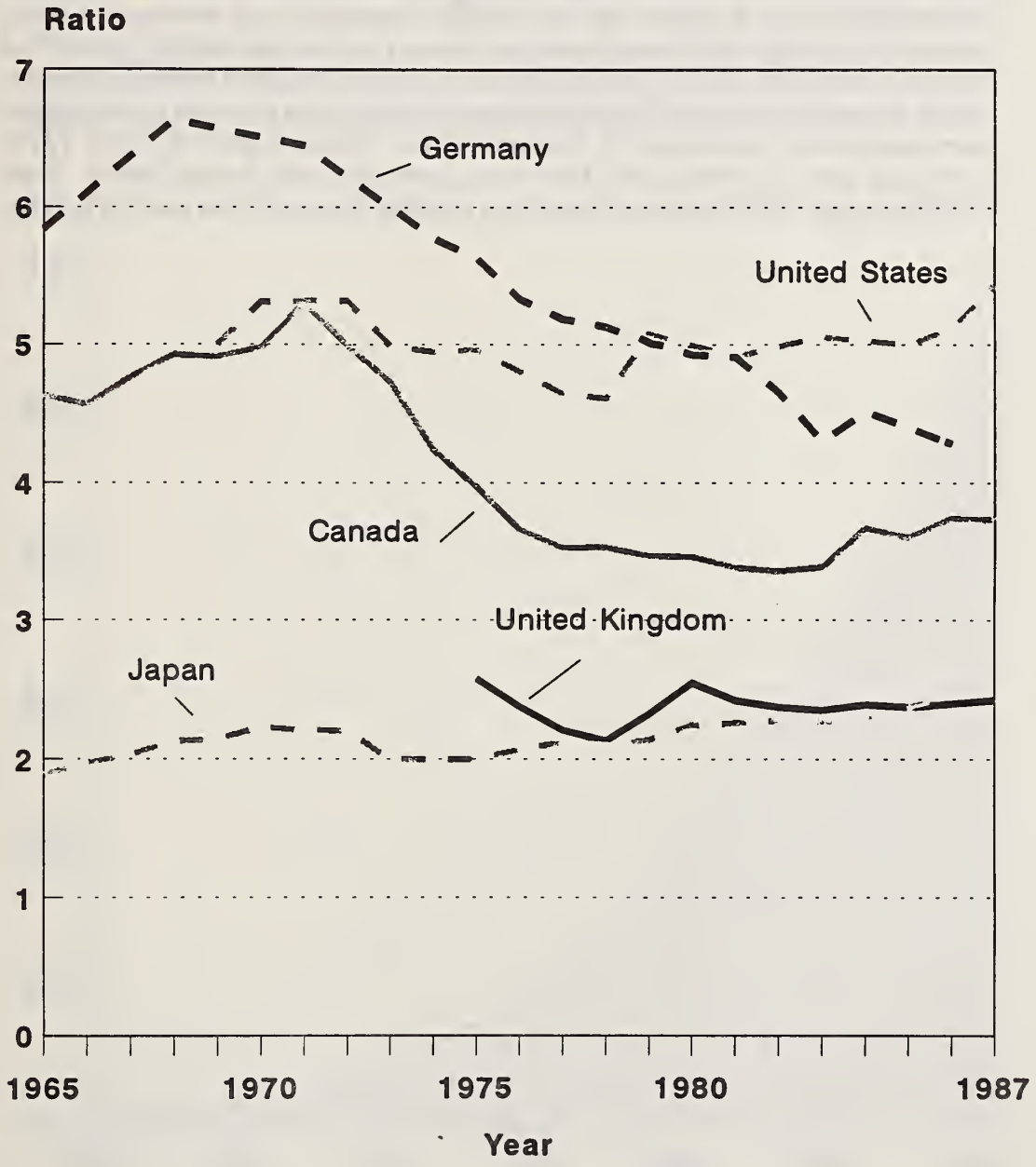
NOTE: Data not available for all countries for all years, missing data for intermediate data points were imputed.

Source: Figure prepared by CRS, based on Organization for Economic Cooperation and Development, Health Data File, 1991

Figure 26. Ratio of Average Income of Physicians to Average Compensation of All Employees, United States and Selected Countries, 1965-1987

The ratio of the average income of physicians in the United States to the average compensation of all employees has been higher than in other countries shown since 1982. Prior to that, West Germany was the only country where the ratio of the average income of physicians to all employees was higher than the U.S. In 1987, the ratio of physician income to all employees' incomes was 5.44 in the U.S.; 3.74 in Canada; 4.29 in West Germany (in 1986); 2.46 in Japan (also in 1986, and 2.42 in the United Kingdom.

Figure 26: Ratio of Average Income of Physicians to Average Compensation of All Employees, United States and Selected Countries, 1965 - 1987



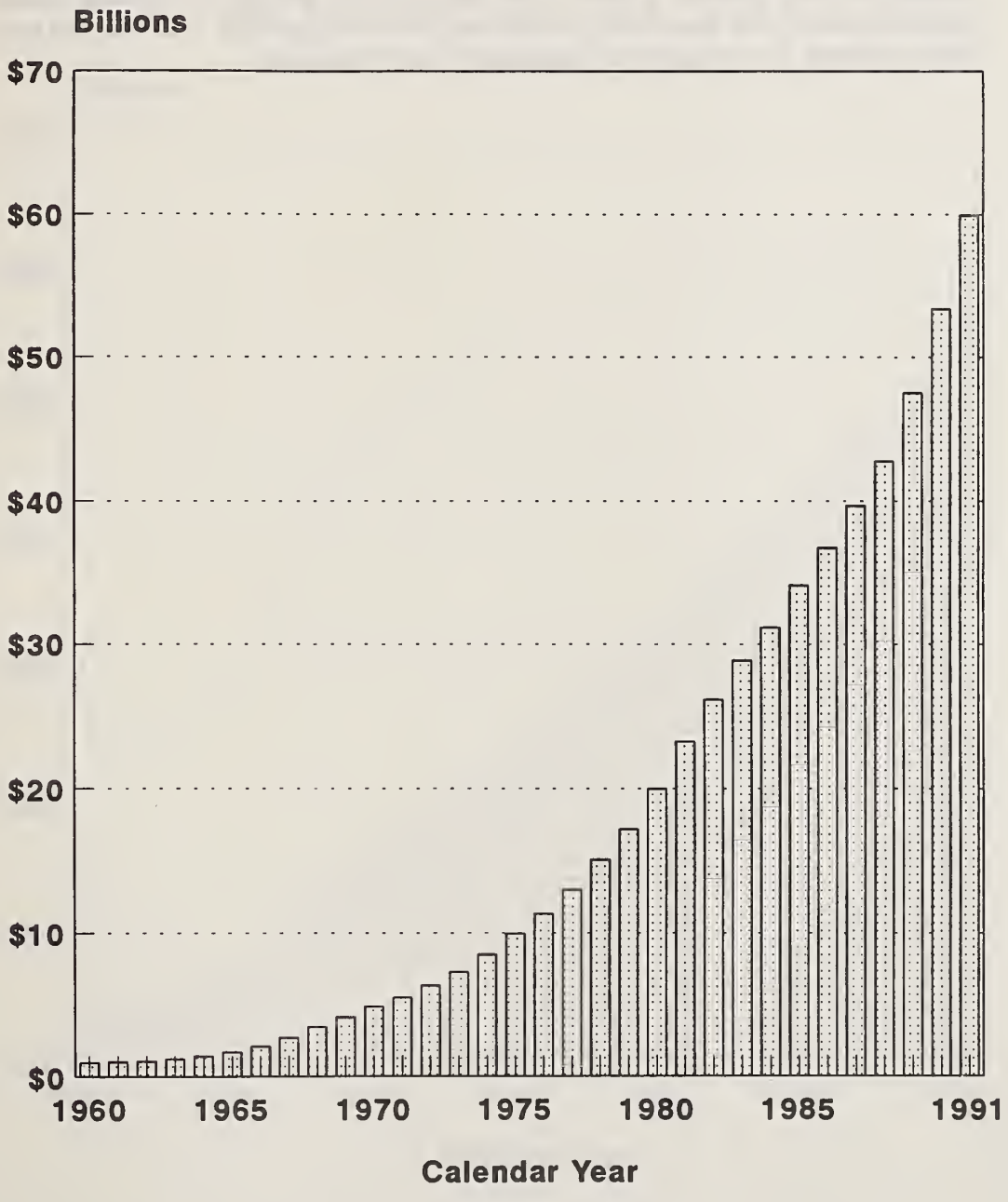
NOTE: Data not available for all countries for all years, missing data for intermediate data points were imputed.

Source: Figure prepared by CRS, based on Organization for Economic Cooperation and Development, Health Data File, 1989

Figure 27. Spending Trends for Nursing Home Services, 1960-1991

Nursing home spending includes care provided in a number of different institutions: skilled nursing facilities, a term often used to describe nursing homes participating in Medicare; nursing facilities participating in Medicaid; intermediate care facilities for the mentally retarded; and veterans' nursing homes. Spending on nursing home care rose at an average annual rate of 14.2 percent from 1960-1991. The highest rate of growth occurred between 1965 and 1970, when Medicare and Medicaid began paying for this care and nursing home services grew an average of 23.4 percent a year. Rates of growth in the 1970's averaged over 15 percent, but have been more moderate in the 1980's. From 1985 through 1991, the rate of growth in nursing home services was 9.8 percent.

Figure 27: Spending Trend for Nursing Home Services, 1960 to 1991

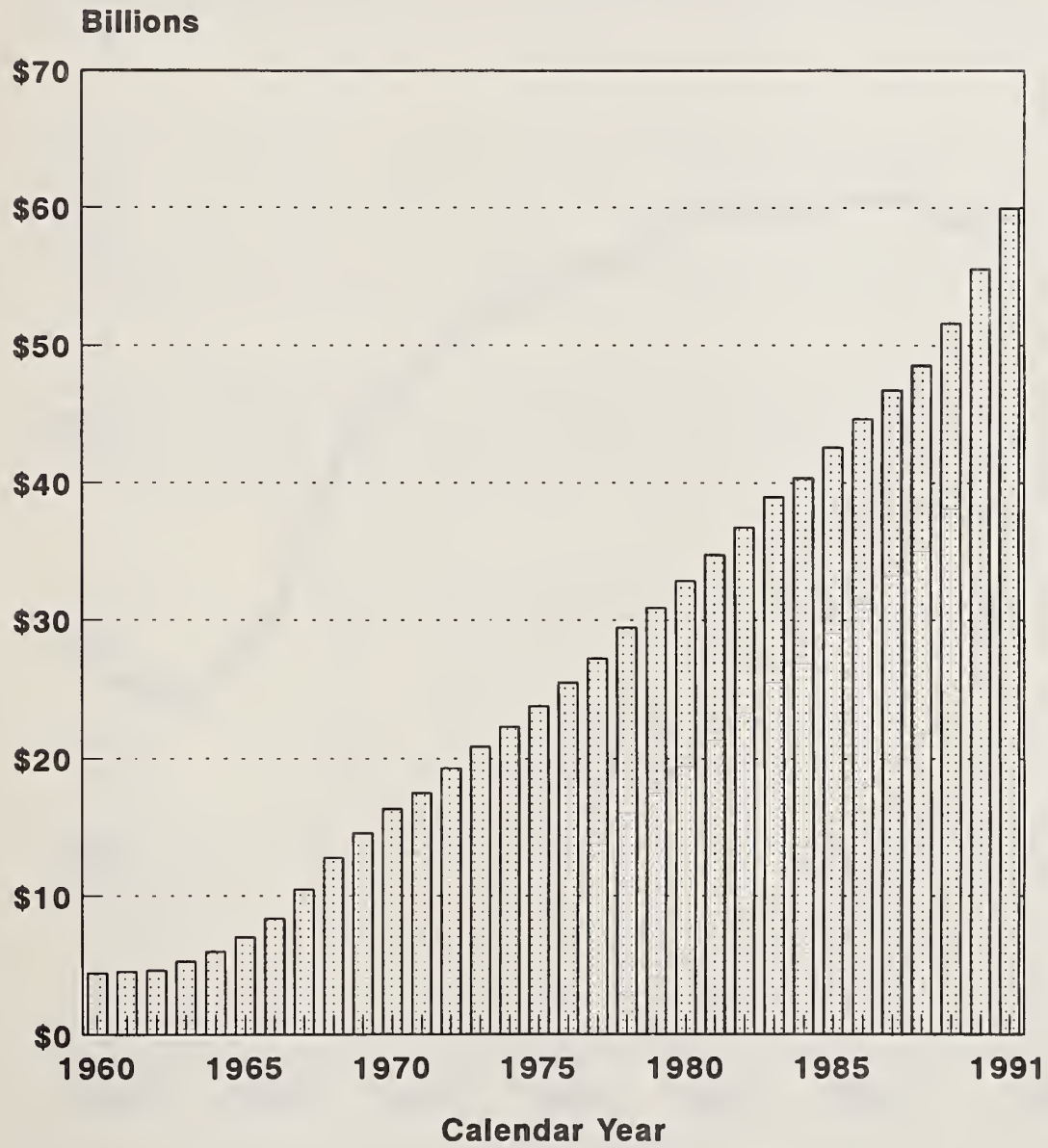


Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

Figure 28. Spending Trends for Nursing Home Services in Constant 1991 Dollars, 1960-1991

Real spending on nursing home services grew an average of 8.8 percent from 1960 through 1991. The most rapid rate of growth in real nursing home spending occurred between 1965 and 1970, when real expenditures grew an average of 18.3 percent a year. The real rate of growth in nursing home spending averaged 5.4 percent a year from 1980 through 1990. In 1991, the real rate of growth in nursing home spending was 8.0 percent.

Figure 28: Spending Trends for Nursing Home Services in Constant 1991 Dollars, 1960 to 1991

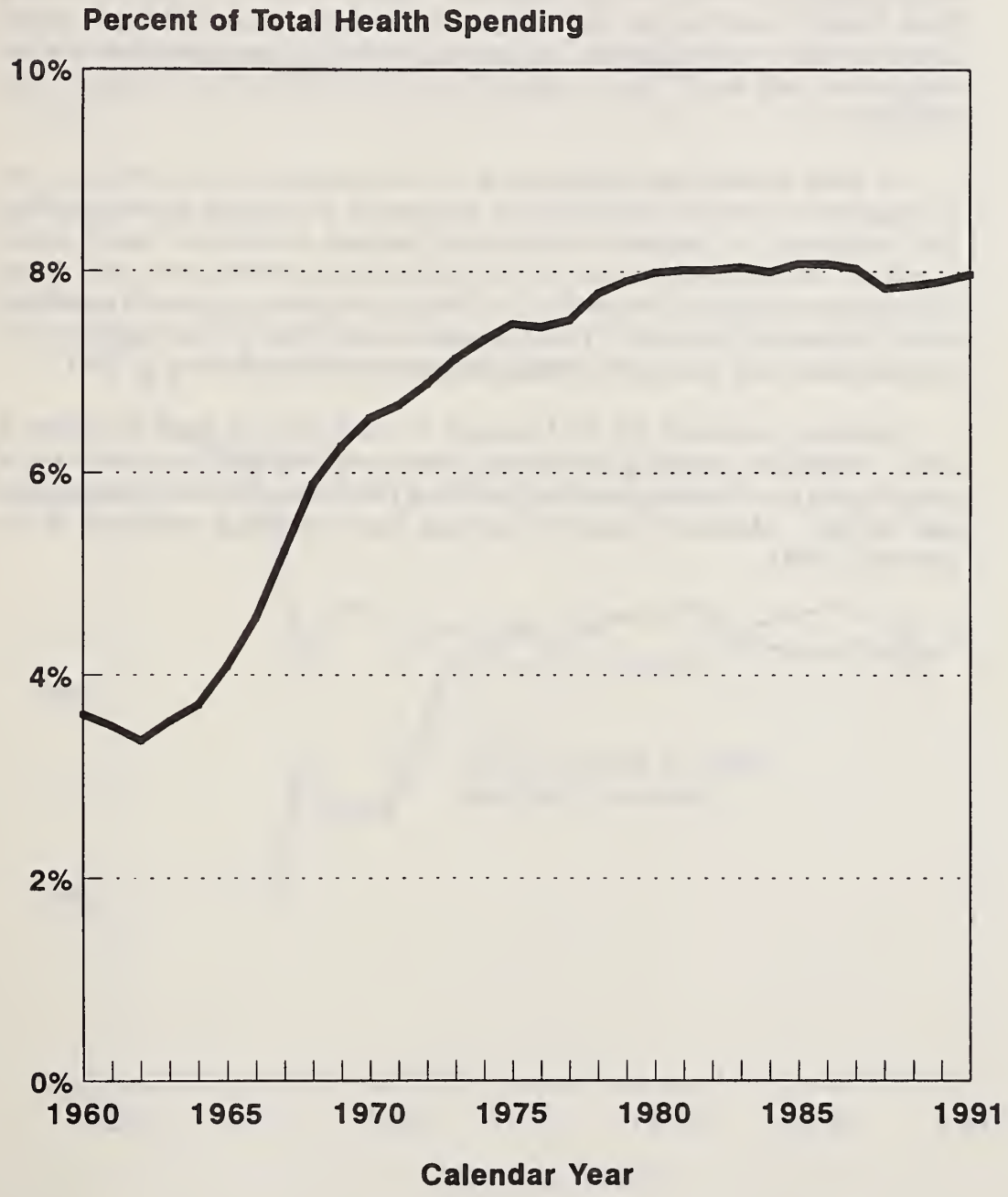


Note: Constant dollar estimates based on implicit price deflator for GDP.
Source: Figure prepared by CRS based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration

Figure 29. Spending for Nursing Home Services as a Share of Total Health Spending, 1960-1991

In 1960, spending for nursing home care constituted 3.6 percent of national health care spending. By 1981, its share of total spending grew to 8.0 percent. Since that time, it has remained relatively constant. In 1991, nursing home spending accounted for 8.0 percent of national health expenditures.

Figure 29: Spending for Nursing Home Services as a Share of Total Health Spending, 1960 to 1991



Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

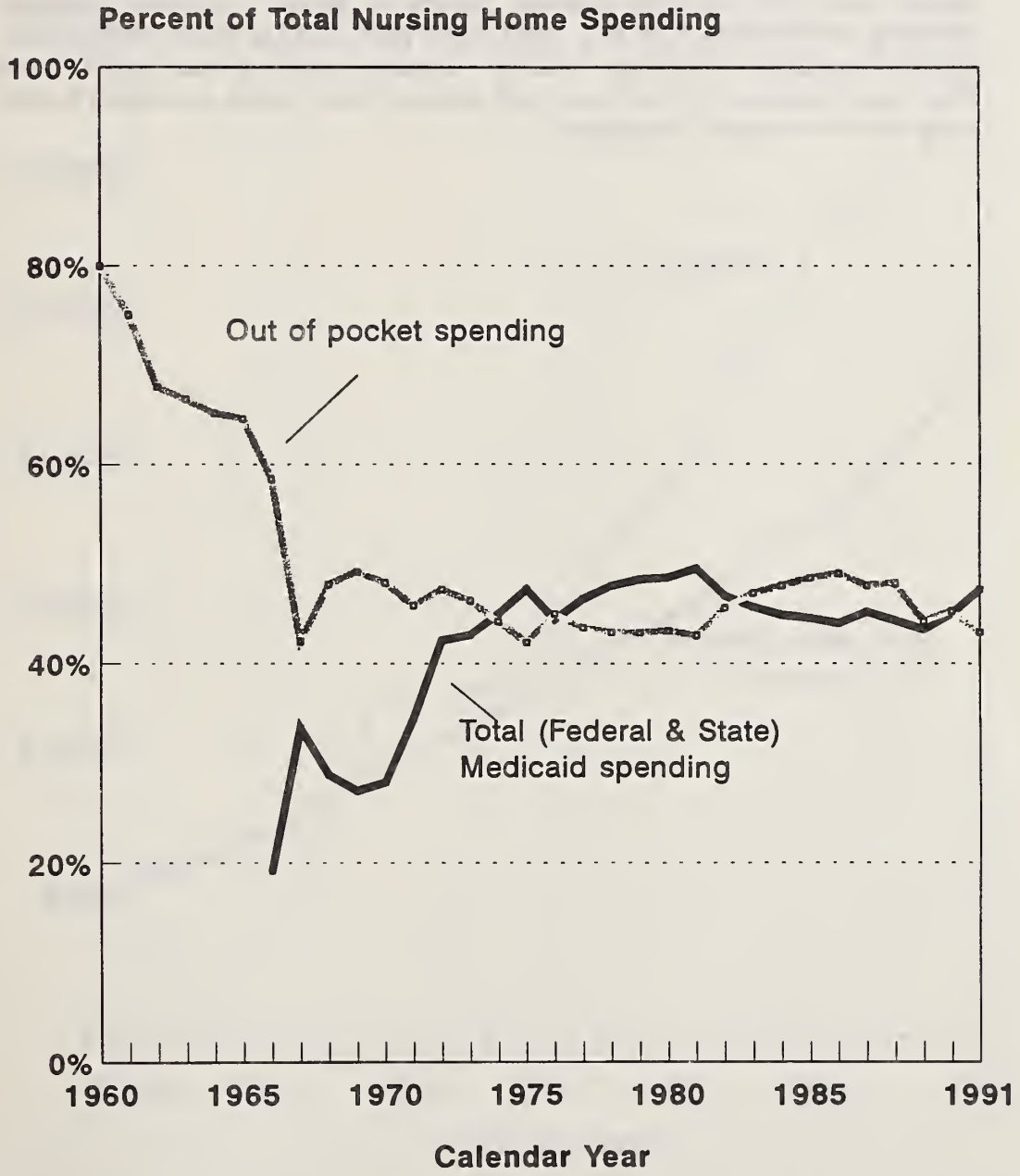
Figure 30. A Comparison of the Share of Nursing Home Spending Paid for by Selected Payers, 1960-1991

The sources of payments for nursing home services are markedly different from those for hospital and physician services. Private insurance has only recently begun covering nursing home care. Medicare has a very limited nursing home benefit, covering only short-stays for persons needing additional skilled care following a hospitalization. As a result, its role in paying for this care has always been very small. Most nursing home care is paid for out-of-pocket or by Medicaid.

In 1960, out-of-pocket payments were the dominant source of funding for nursing home services, comprising 80 percent of all nursing home spending. The enactment of Medicaid substantially reduced consumers' out-of-pocket payments. In 1970, 48 percent of all nursing home services were paid for by consumers out of their own pocket. In 1991, out-of-pocket payments accounted for 43 percent of the total. Private insurance and other private payments for nursing home care amounted to only 3 percent of total spending in 1991.

Medicaid accounted for 47.4 percent of total nursing home spending in 1991. Medicaid's spending for nursing home care is driven by its coverage of persons who have become poor after depleting their resources and income on the cost of care. Medicare's share of nursing home spending amounted to 4.4 percent in 1991.

Figure 30: Selected Sources of Payment for Nursing Home Services, 1960 to 1991

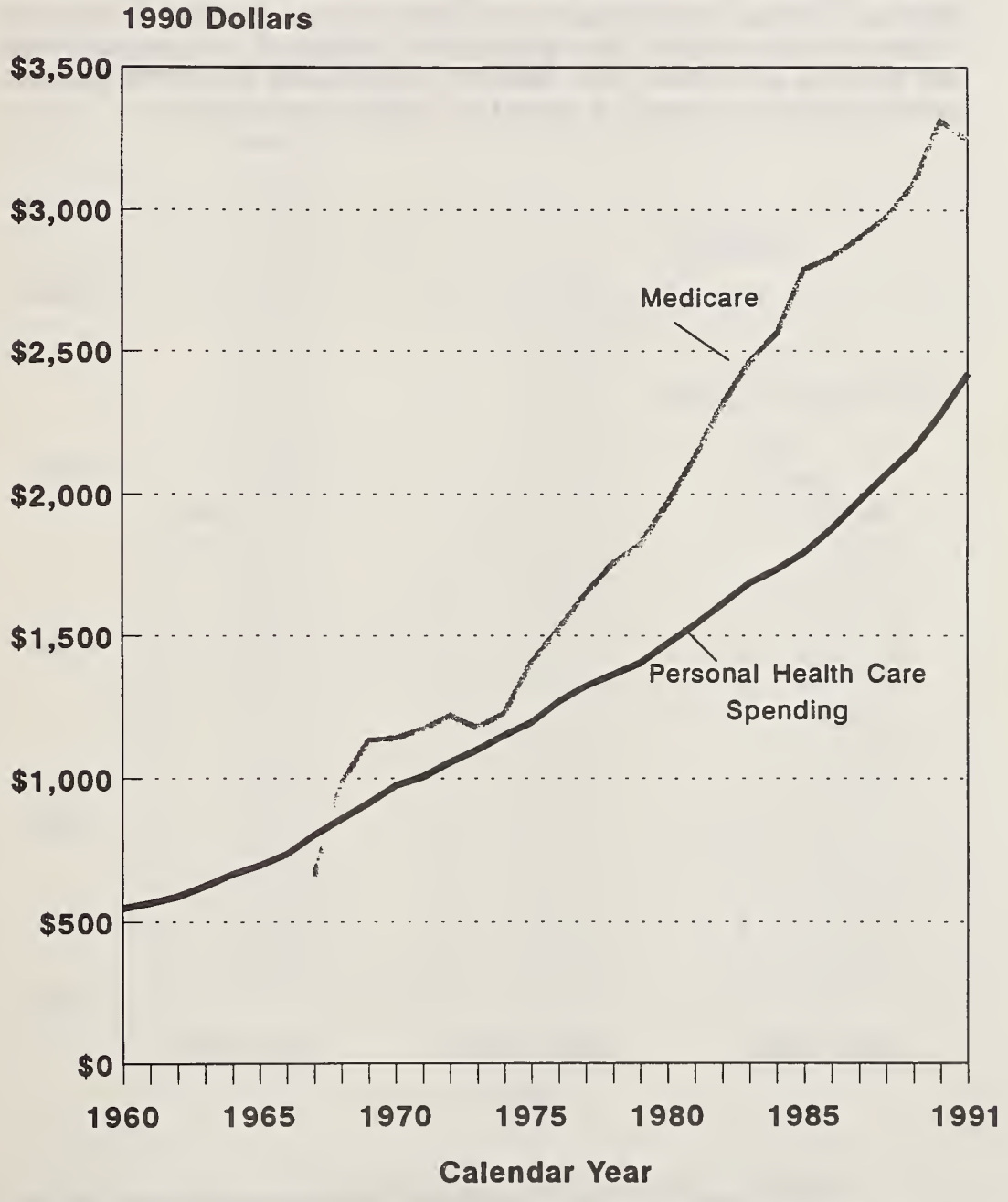


Source: Figure prepared by CRS based on National Health Expenditures, Office of the Actuary, Health Care Financing Administration

Figure 31. Real Per Capita National Expenditures and Per Enrollee Medicare Expenditures for Health, 1965-1991

Real Medicare spending per enrollee has risen faster than real national health spending per capita. Between 1970 and 1991, real Medicare spending per enrollee nearly tripled from $1,139 (in 1990 constant dollars) to $3,245. During the same period, real national health spending per capita increased about 2.4 times, from $975 (in 1990 constant dollars) to $2,420. In part, Medicare spending per enrollee rose at a more rapid pace because of the inclusion of disabled enrollees in Medicare in 1974. Disabled enrollees incur higher costs than aged enrollees. In addition, aged persons have higher per capita health costs than do nonaged individuals.

Figure 31: Real Per Capita Expenditures and Per Enrollee Medicare Expenditures, 1960-1991

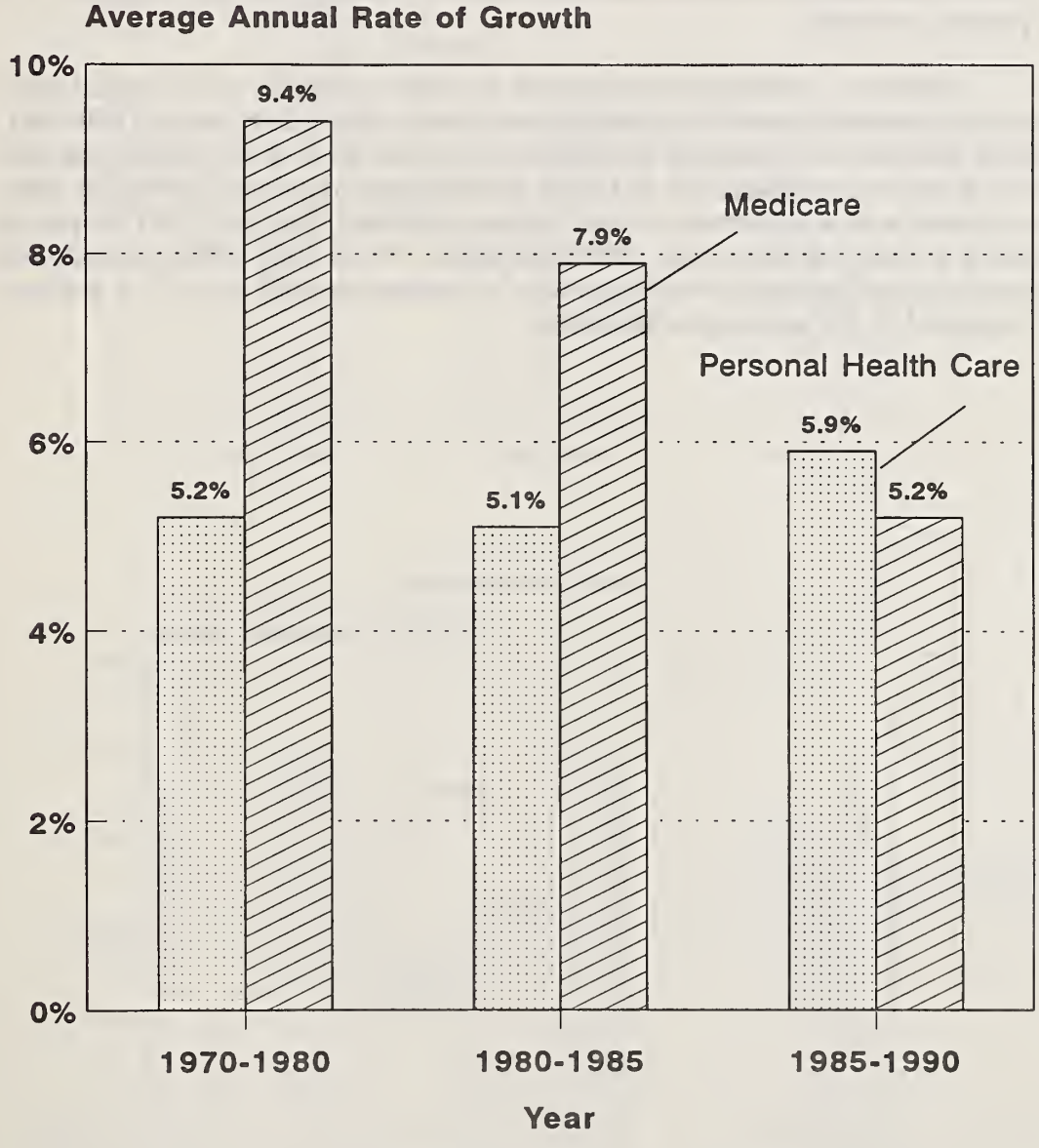


Source: Figure prepared by CRS, based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration and CBO estimates of Medicare per enrollee spending

Figure 32. Average Annual Growth Rates of Real National and Medicare Expenditures for Health, 1970-1990

Between 1970 and 1980, real Medicare spending rose at an average annual rate of 9.4 percent, compared with 5.2 percent for real personal health care spending. Through the first half of the 1980s, Medicare spending continued to outpace national spending. During the 1985 to 1990 period, real personal health care spending grew faster than Medicare spending--5.9 percent for personal health expenditures versus 5.2 percent for Medicare expenditures.

Figure 32: Average Annual Growth Rate of Real Medicare and Personal Health Care Spending, 1975-1990



NOTE: All real expenditures calculated using implicit price deflator for GDP.

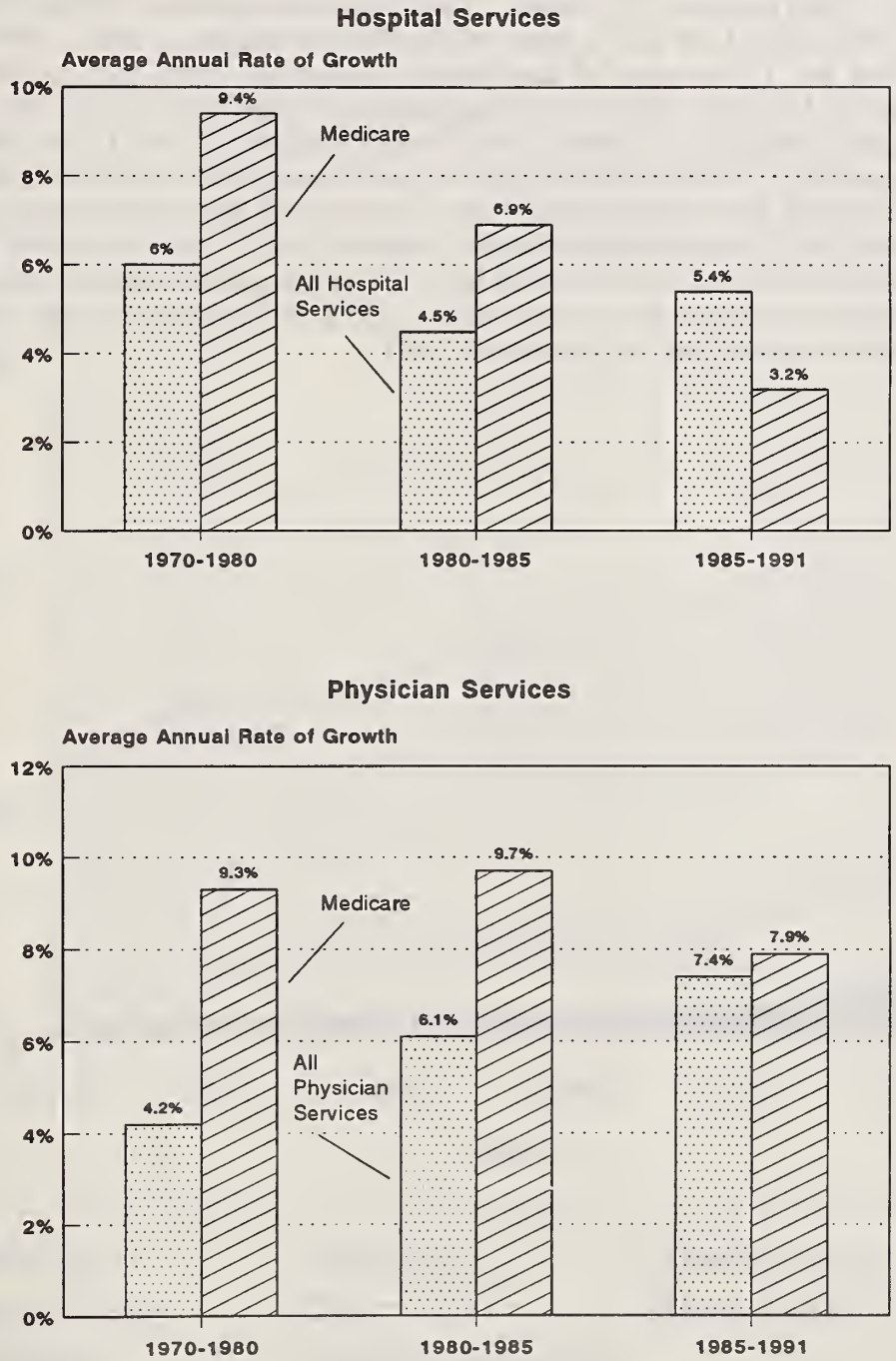
Source: Figure prepared by CRS, based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration.

Figure 33. Average Annual Growth Rates of Real National and Medicare Expenditures for Hospital and Physician Services, 1970-1991

Medicare expenditures for hospital services increased more rapidly than national expenditures during the 1970-1980 period and the 1980-1985 period. From 1985 through 1991, however, Medicare hospital spending rose only 3.2 percent annually, while national spending for hospital services increased 5.4 percent annually.

Medicare's spending for physician services increased more rapidly than national expenditures for physician care during the entire period 1970-1991. Real Medicare expenditures for physician services grew at an annual real rate of 9.3 percent between 1970 and 1980, and 9.7 percent between 1980 and 1985, compared with a 4.2 percent annual increase nationally for the 1970-1980 period and a 6.1 percent rate in the 1980-1985 period. From 1985-1991, real national spending for physician services grew at an average annual rate of 7.4 percent, compared to 7.9 percent for Medicare.

Figure 33: Average Annual Growth Rate of Real National and Medicare Expenditures for Hospitals and Physician Services, 1970-1991

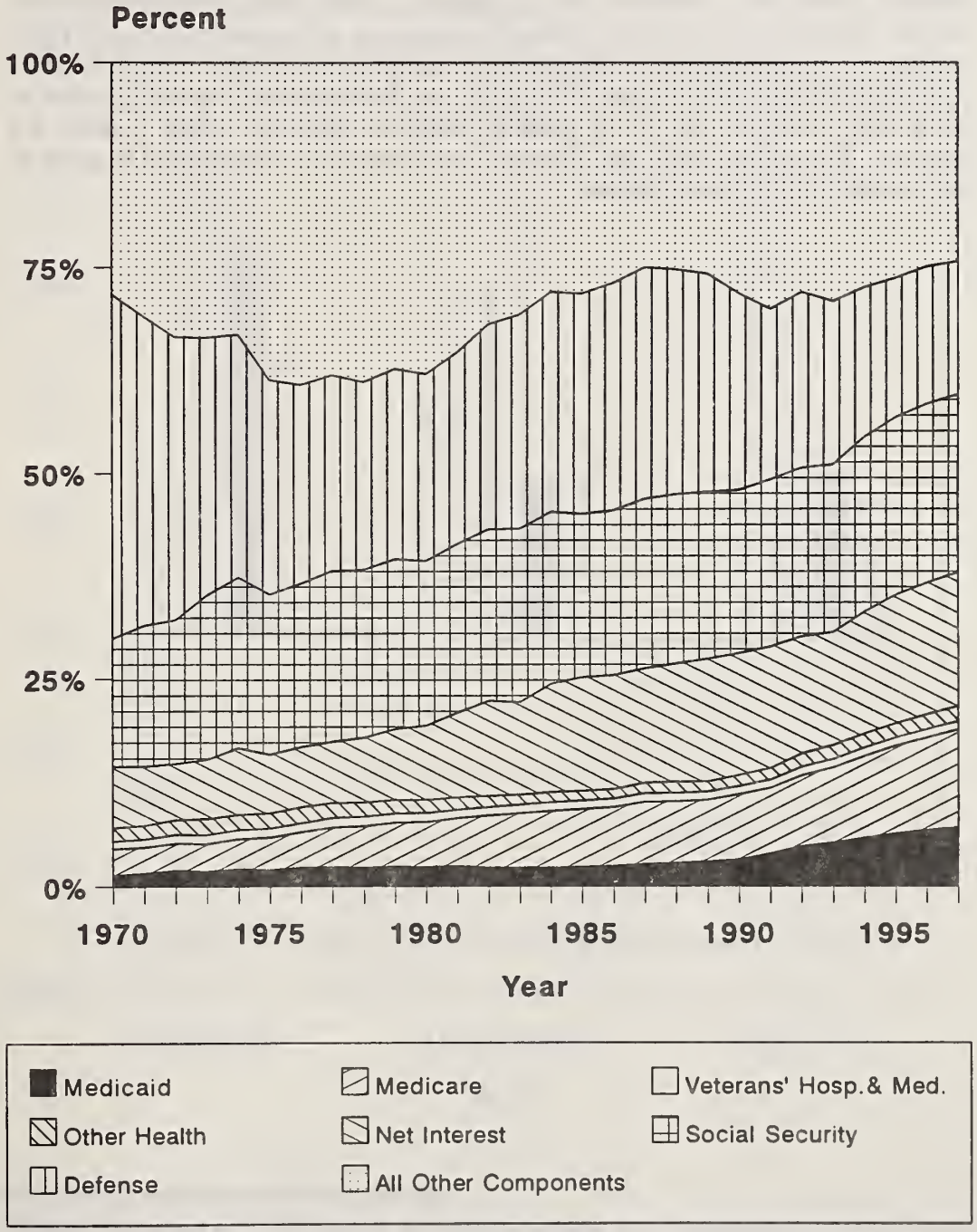


Source: Figure prepared by CRS based on National Health Expediture data, Office of the Actuary, Health Care Financing Administration

Figure 34. Selected Components of the Federal Budget, 1970-1997 (in percent)

In 1970, Medicare spending accounted for 3.2 percent of the Federal budget; by 1991, it had grown to 7.9 percent. The Congressional Budget Office projects that it will account for 11.7 percent of the Federal budget by 1997. Medicaid accounted for 1.4 percent of the Federal budget in 1970 and in 1991 it represented 4 percent. Recent rapid spending increases result in the Medicaid growing to a projected 7.2 percent of the Federal budget by 1997. Other Federal health spending, which includes veterans' health care, other health services and health research (but excludes health care outlays in the Department of Defense) accounted for 2.5 percent of the Federal budget in 1970, 2.4 percent in 1991, and is projected to account for 2.8 percent in 1997. By comparison, defense spending accounted for 41.8 percent of the budget in 1970, 20.7 percent in 1991, and is projected to account for 16.2 percent in 1997.

Figure 34: Selected Components of the Federal Budget, 1970-1997

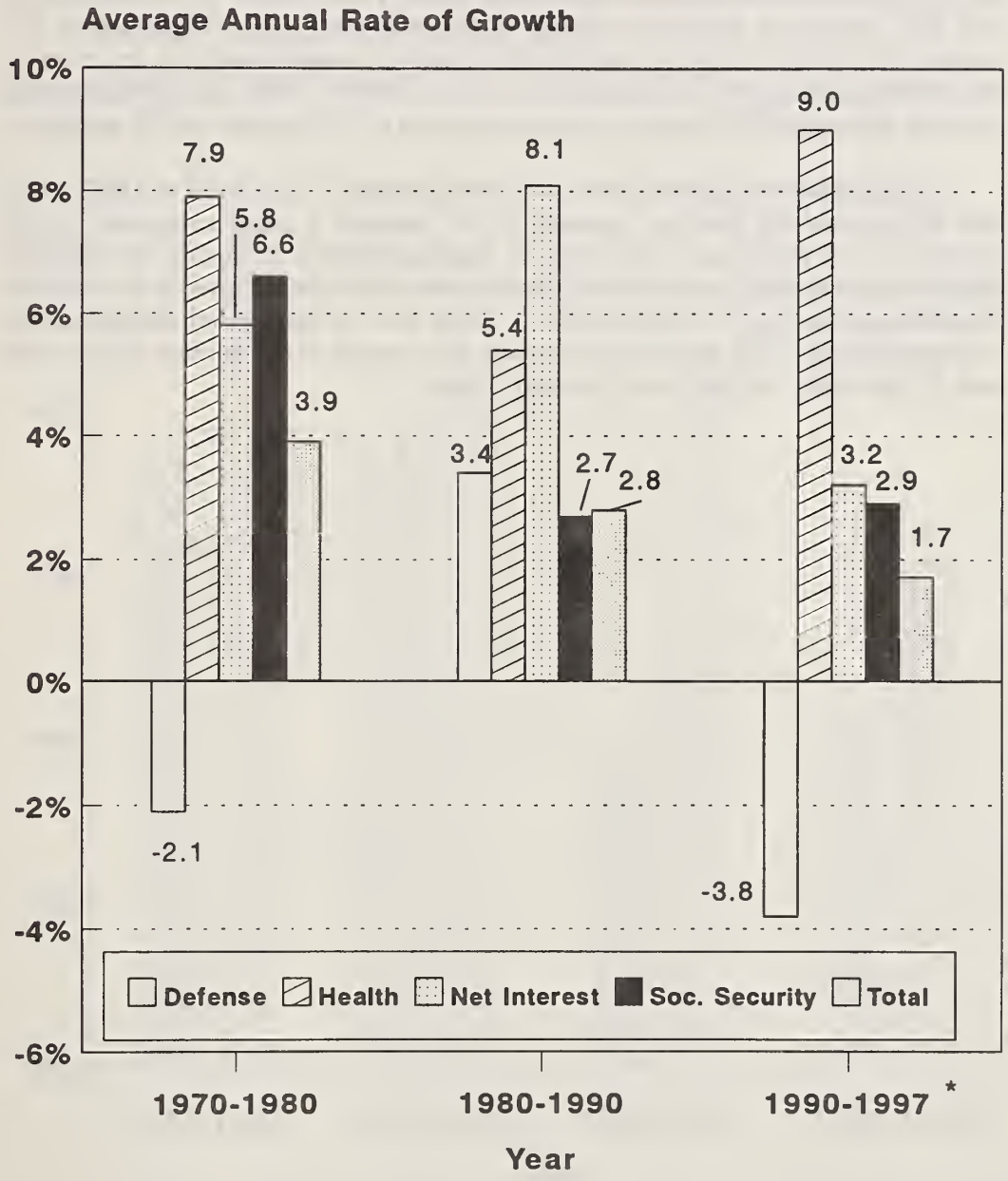


Source: Figure prepared by CRS based on the Federal Budget 1970-1991 and CBO projections 1992-1997

Figure 35. Average Annual Rates of Growth of Real Federal Outlays, Selected Components, 1970-1997

Between 1970 and 1980, the average annual rate of growth in real spending in the Federal budget was 3.9 percent; between 1980 and 1990, it grew an average of 2.8 percent a year. The Congressional Budget Office projects that the Federal budget will increase only 1.7 percent a year from 1990-1997 in real terms. Health spending in the Federal budget grew at consistently higher rates during those periods, and is projected to increase faster than overall Federal spending through 1997. From 1970-1980, real Federal health spending grew at an average annual rate of 7.9 percent; between 1980 and 1990, it grew 5.4 percent. From 1990-1997, real Federal health spending is projected to grow at an average of 9.0 percent a year.

Figure 35: Average Annual Growth Rates of Real Federal Outlays, 1970-1997



*** Projections are estimates subject to change.**

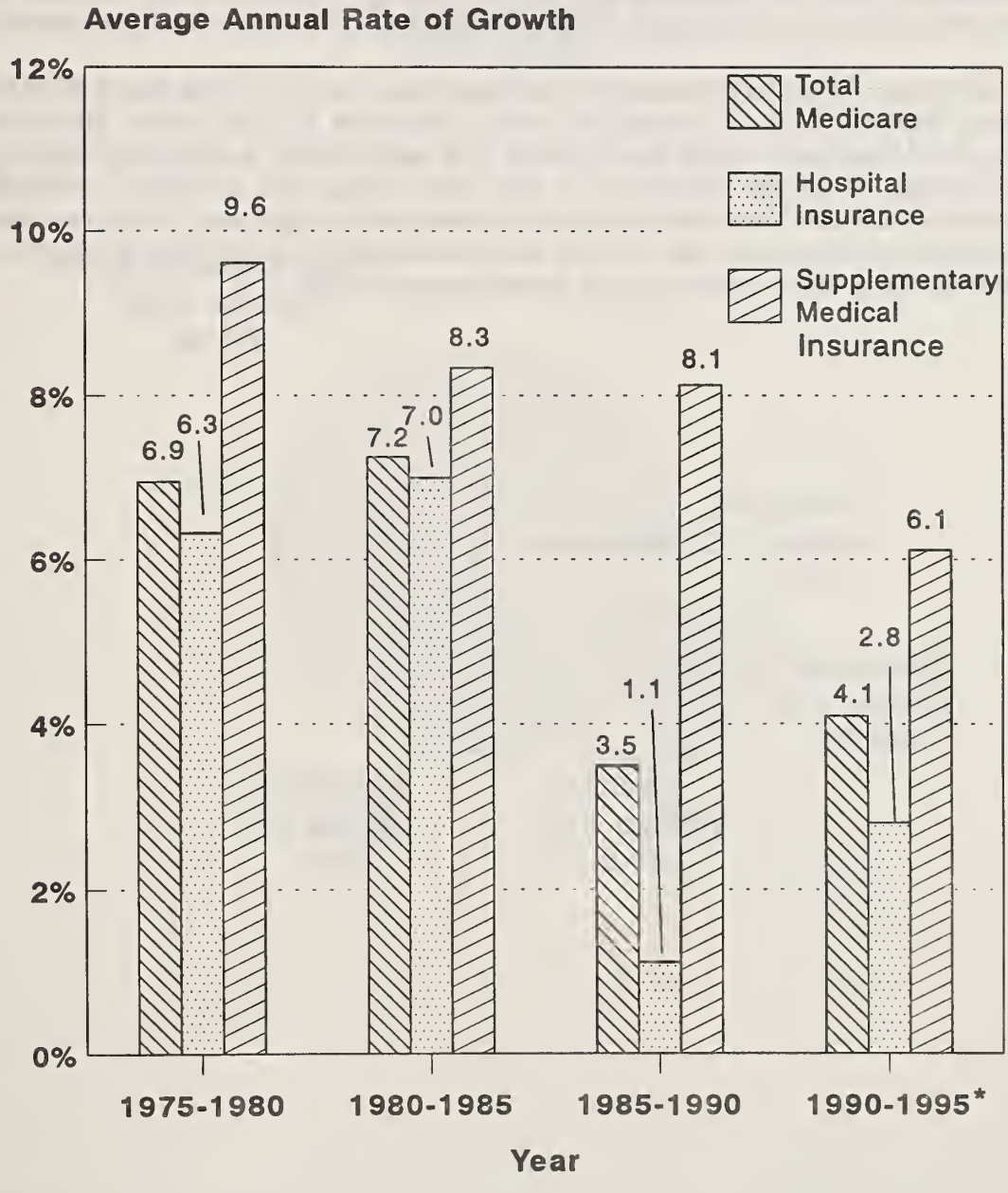
Source: Figure prepared by CRS based on actual outlays and Congressional Budget Office projections from August 1992

Figure 36. Average Annual Growth Rates of Real Medicare Spending, Per Enrollee, By Component, 1975-1995

From 1975 through 1990, Medicare real spending per enrollee grew fastest for Medicare Part B spending--physician and other outpatient spending financed by the Supplementary Medical Insurance (SMI) Trust Fund. From 1975-1980, real SMI spending grew an average of 9.6 percent a year, compared to 6.3 percent for Medicare Part A spending for inpatient hospital services financed by the Hospital Insurance (HI) Trust Fund. From 1980 to 1985, real SMI spending grew an average of 8.3 percent a year, compared to 7.0 percent for HI spending.

The difference in growth rates was most dramatic from 1985 to 1990, when real SMI spending grew an average of 8.1 percent a year, compared to 1.1 percent for HI spending. This reflects implementation of Medicare's hospital prospective payment system which has slowed the rate of growth in hospital spending under Part A. From 1990 to 1995, the Congressional Budget Office projects that real SMI spending will grow an average of 6.1 percent a year, and real HI spending will grow 2.8 percent a year.

Figure 36: Average Annual Growth Rates of Real Medicare Spending Per Enrollee, 1975-1995



*** 1995 estimates are projections subject to change.**

Source: Figure prepared by CRS, based on Congressional Budget Office estimates and projections prepared in May 1992

Figure 37: Primary Sources of Health Coverage for Persons Under Age 65, 1991

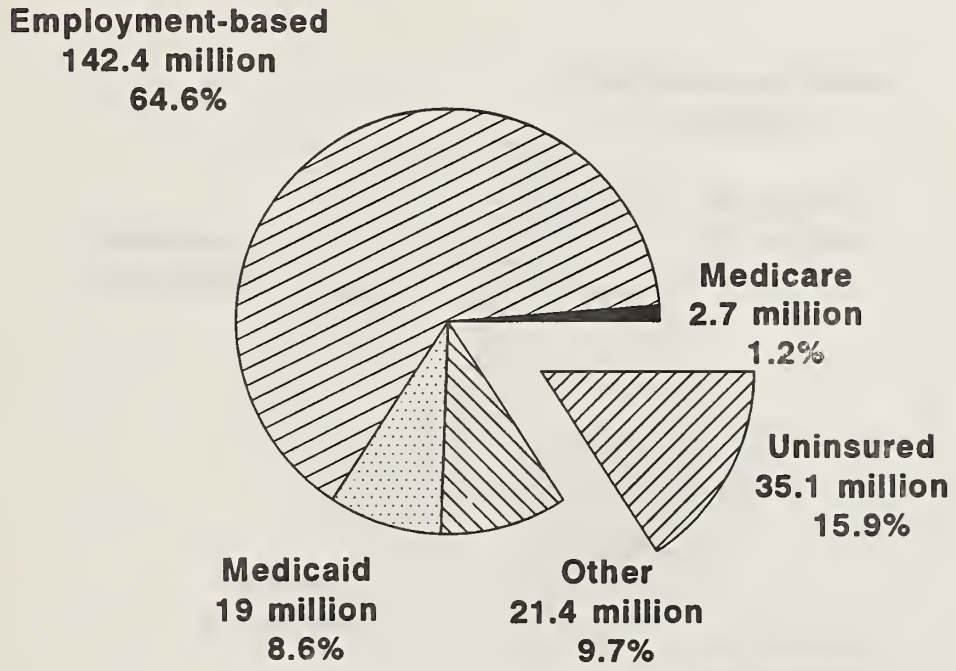
In 1991, an estimated 84 percent of the noninstitutionalized population under age 65 had public or private coverage during at least part of the year. Employer plans covered 142 million Americans in 1991, or nearly two-thirds of the nonaged population. Persons covered under employer plans are almost equally divided between those obtaining coverage through their own work and those obtaining coverage as dependents on another family member's policy.

Estimates in Figures 37 through 47 are based on an analysis of the March 1992 Current Population Survey (CPS), a household survey conducted by the Census Bureau of the Department of Commerce. Each year's March CPS asks whether persons had coverage from selected sources of health insurance at any time during the preceding calendar year. Respondents could have more than one kind of insurance during a year. Except as noted, the figures assign an individual to one primary source of coverage, on the basis of which coverage would usually be primary under medical claims payment rules.

Figure 37: Primary Sources of Health Coverage for Persons under Age 65, 1991

Persons covered in millions

Total Persons under 65
220.6 million



Source: CRS analysis of March 1992 Current Population Survey

Figure 38: Primary Sources of Health Coverage, Persons in Poverty, 1991

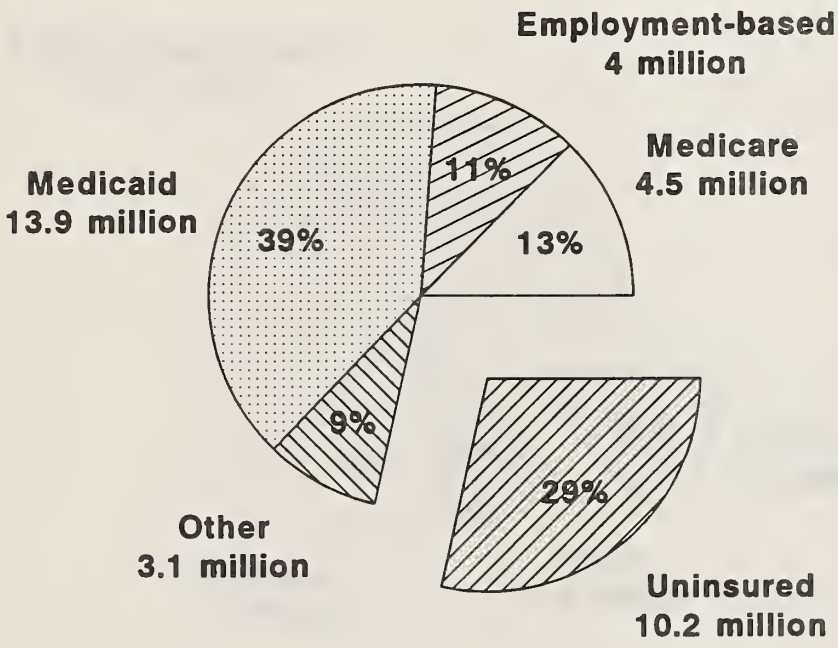
Persons with incomes below the Federal poverty level are less likely than higher-income persons to have coverage; those who do have coverage are more likely to rely on Medicaid or on the sources of insurance classed as 'other.' These include non-employer based private coverage, State and local indigent care programs, and miscellaneous other sources of coverage. Note that this figure includes persons over 65, most of whom have Medicare.

For purposes of computing income, individuals have been assigned to "insurance units," groupings that meet the typical private insurance definition of a "family." Incomes of these units were then compared to the 1991 Federal poverty levels for families of the same size. (For a family of four, this figure was $13,924 in 1991.)

Figure 38: Primary Sources of Health Coverage, Persons in Poverty, 1991

Persons covered in millions

Total poor population
35.7 million



Source: CRS analysis of March 1992 Current Population Survey

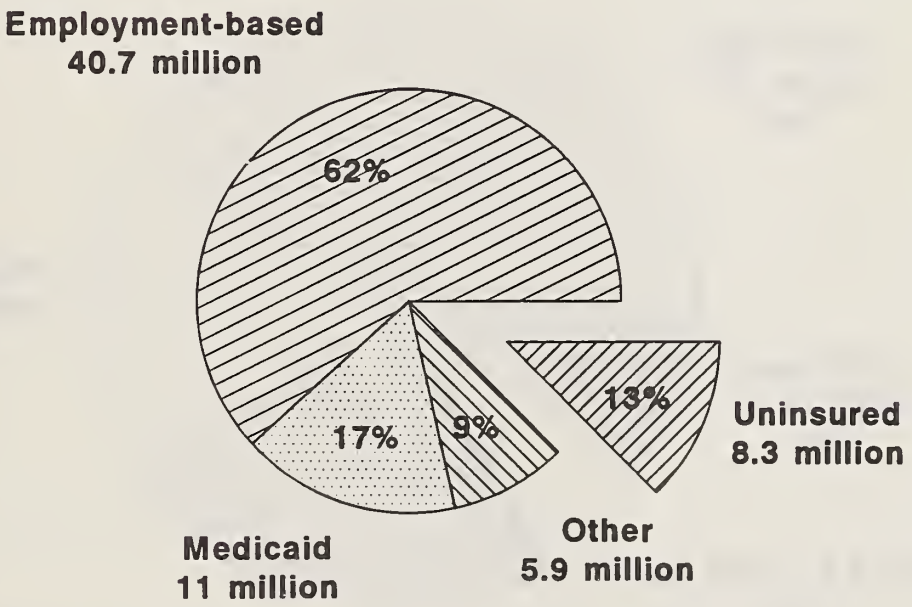
Figure 39: Primary Sources of Health Coverage for Children Under Age 18, 1991

Most children are covered as dependents under a parent's work-based coverage. Medicaid is the second most important source of coverage for children, and even more children are expected to receive Medicaid as a result of expansions enacted in 1989 and 1990. While 13 percent of all children had no insurance during 1991, the rate of uninsurance is much higher (20.5 percent) for those under poverty. All poor children will eventually be eligible for Medicaid under the phased-in OBRA 90 expansions.

Figure 39: Primary Sources of Health Coverage for Children under Age 18, 1991

Persons covered in millions

Total persons under 18
65.9 million



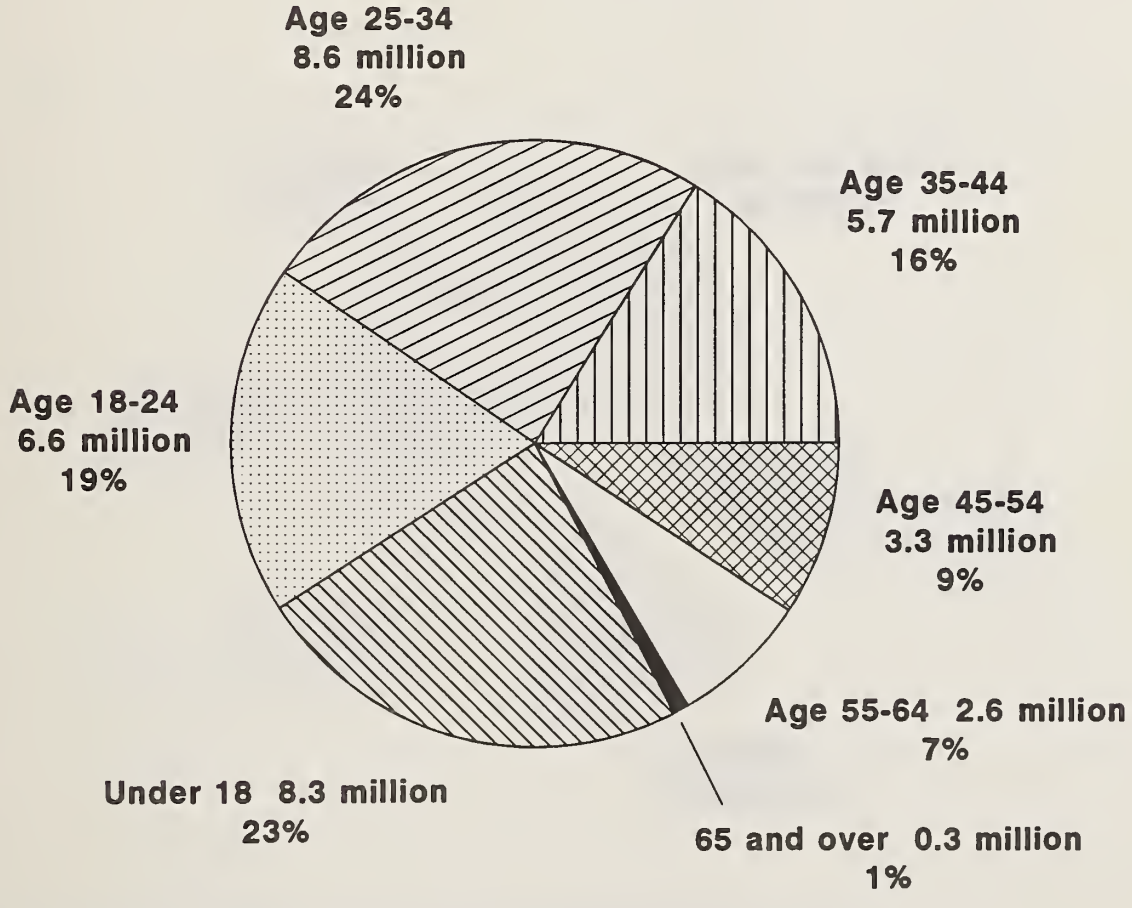
Source: CRS analysis of March 1992 Current Population Survey

Figure 40: Population Without Health Coverage by Age, 1991

Over two-fifths of the uninsured in 1989 -- 42 percent -- were under age 24. Children accounted for 23 percent of the uninsured, and young adults for another 19 percent. Older adults make up a much smaller proportion of the uninsured. However, because they are likely to require more health services, they may contribute disproportionately to such problems as uncompensated care in hospitals.

Figure 40: Population without Health Coverage by Age, 1991

Persons in millions



Source: CRS analysis of March 1992 Current Population Survey

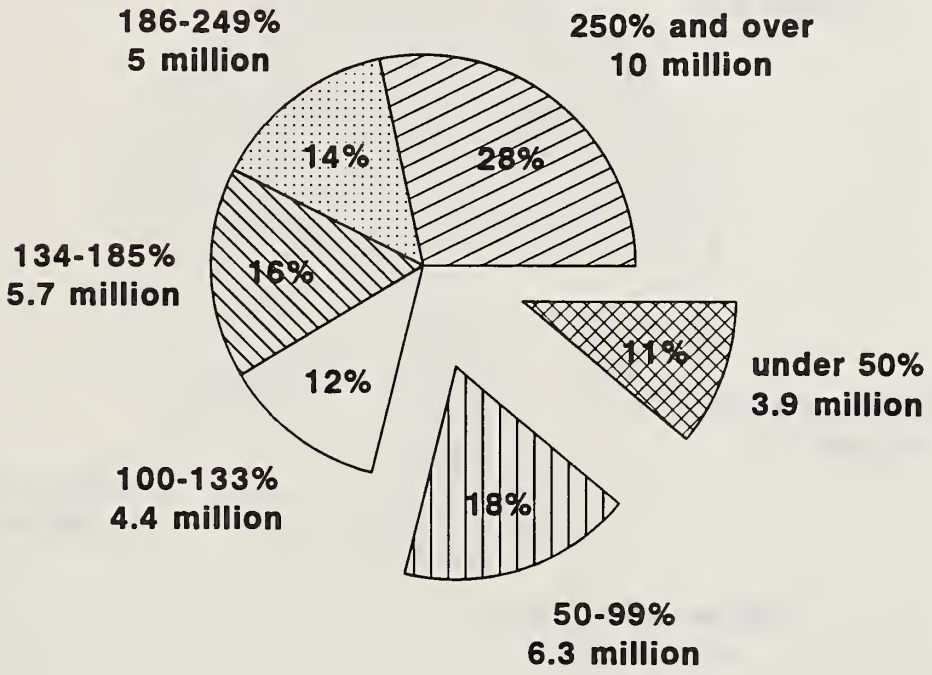
Figure 41: Population Without Health Coverage by Income, 1991

Persons with incomes below the Federal poverty level account for 29 percent of the uninsured population, and another 42 percent have incomes between 100 and 250 percent of poverty. Despite the strong association of income and insurance status, nearly one in three uninsured persons has an income of 250 percent of poverty or more.

Figure 41: Population without Health Coverage by Income, 1991

Persons in millions

Population without Health Insurance
35.4 million



Income as a Percent of Federal Poverty Level

Source: CRS analysis of March 1992 Current Population Survey

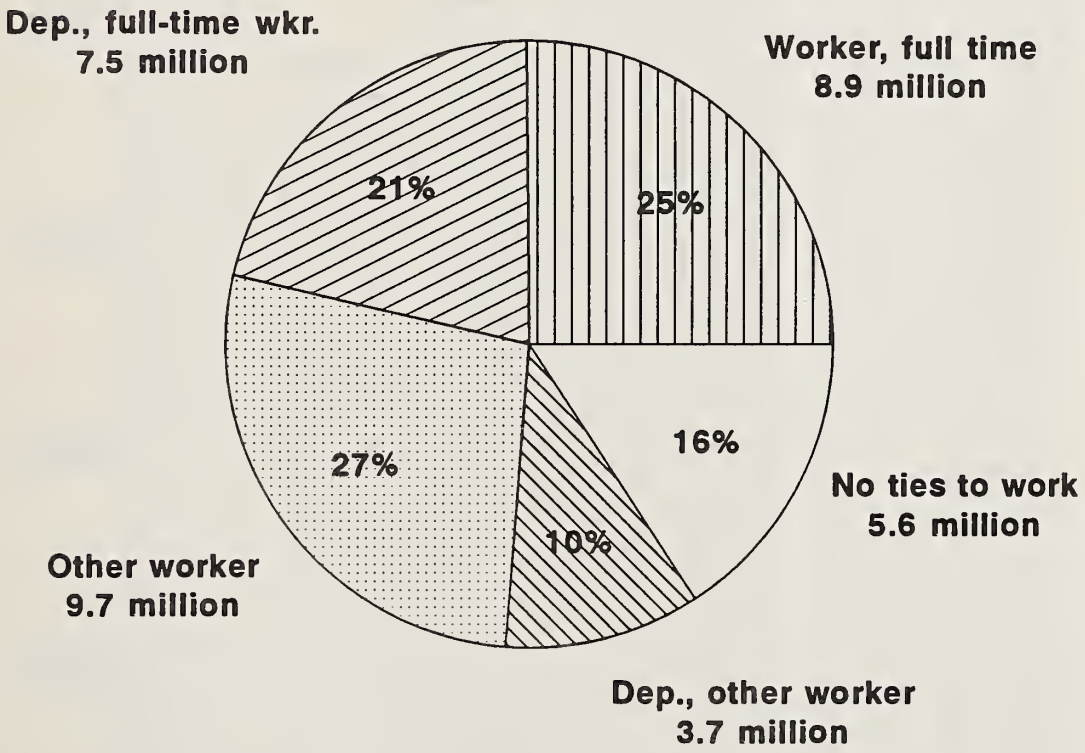
Figure 42: Population Without Health Coverage by Ties to Work Force, 1991

Nearly half the uninsured (46 percent) worked full time throughout 1991, or were dependents of such workers. Workers who worked only part time or only during part of the year were more likely to lack coverage. Employers who cover their full time employees generally have a minimum hours-per-week threshold for coverage, while seasonal industries often provide no coverage. Only 5.6 million of the uninsured, about one in six, had no ties to the work force at any time during the year.

Figure 42: Population without Health Coverage by Ties to Work Force, 1991

Workers and dependents (millions)

Population without Health Insurance
35.4 million



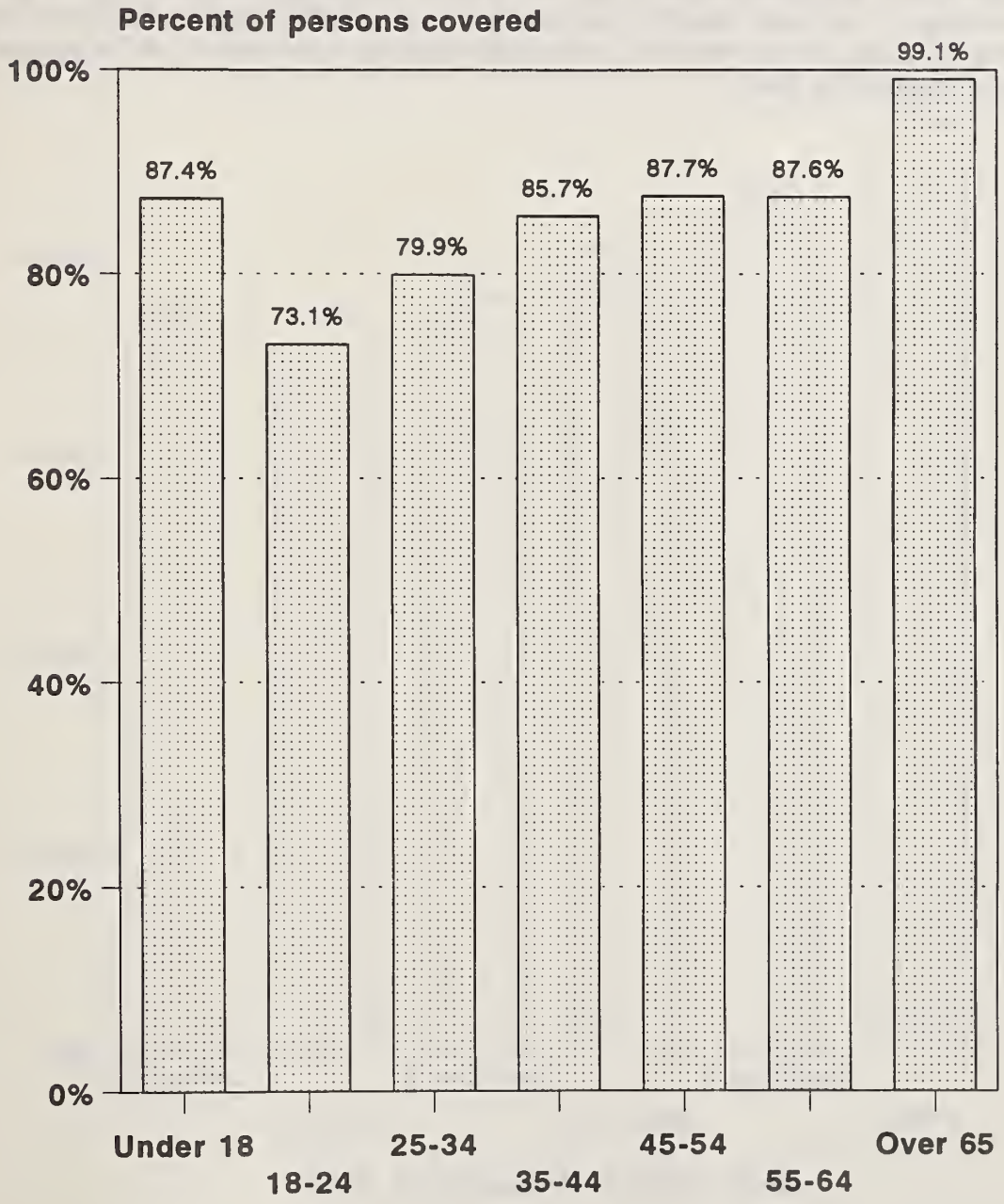
NOTE: Full-time workers worked at least 35 hours per week for at least 50 weeks.

Source: CRS analysis of March 1992 Current Population Survey

Figure 43: Rate of Health Coverage by Age, 1991

The rate of insurance coverage is lowest among young adults. Nearly 27 percent of persons ages 18 to 24 were without coverage in 1991. Young adults may be unemployed or in entry level jobs that do not offer coverage. If they are still living at home, they may not be counted as dependent children for the purposes of either private insurance or Medicaid. Over the next several age groups, coverage rates increase, chiefly because older workers are more likely to obtain insurance through their own employment. Finally, the availability of Medicare to most individuals aged 65 and over meant that less than 1 percent of this group was uninsured.

Figure 43: Rate of Health Insurance Coverage by Age, 1991

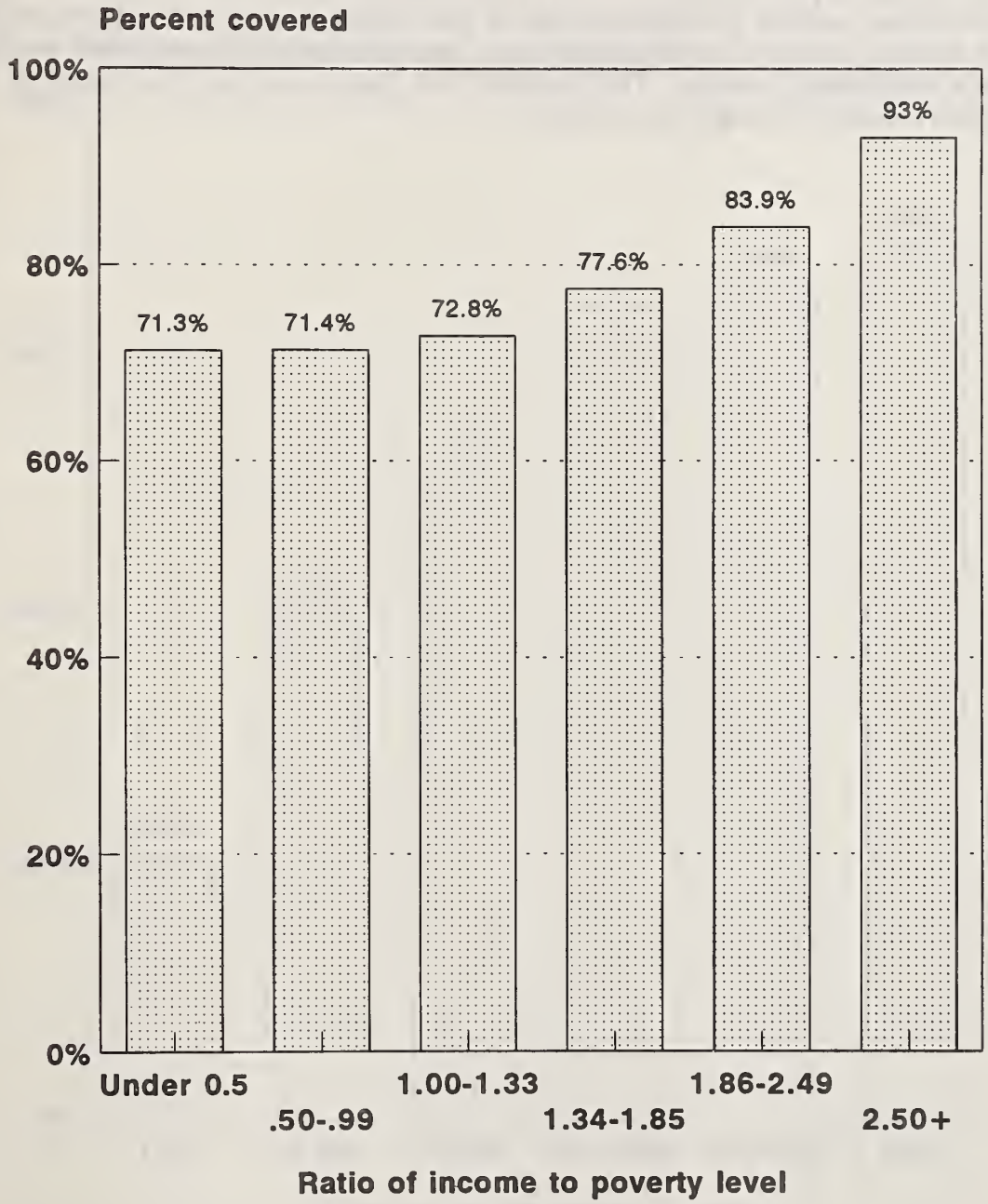


Source: CRS analysis of March 1992 Current Population Survey

Figure 44: Rate of Health Insurance Coverage by Income, 1991

Persons with incomes over 250 percent of the poverty level are 30 percent more likely to have health insurance than the poorest Americans, those with incomes below 50 percent of poverty. Although recent Medicaid expansions have improved coverage rates, only 71 percent of those in the lowest income group had coverage in 1991. Some of the uninsured poor may be excluded from Medicaid because they fail to meet categorical standards, which generally limit coverage to the aged, disabled, and families with children. Others may have incomes exceeding Medicaid limits, which for some individuals in some States can be as low as 16 percent of the poverty level.

Figure 44: Rate of Health Insurance Coverage by Income, 1991

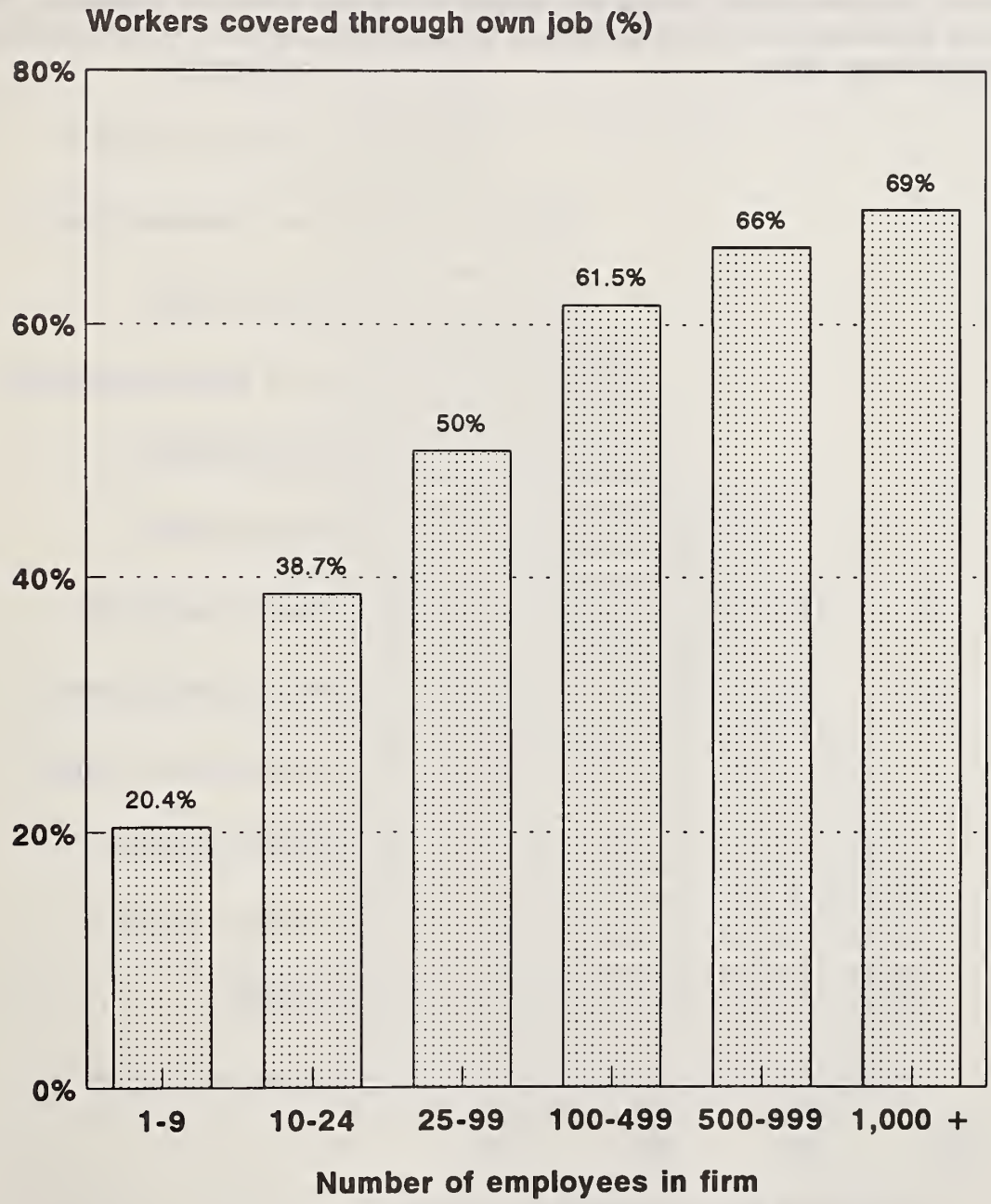


Source: CRS analysis of March 1992 Current Population Survey

Figure 45: Rate of Health Insurance Coverage by Size of Employer, 1991

The likelihood that a worker will obtain coverage through his or her own employment varies with the size of the employer. A Health Insurance Association of America (HIAA) survey in 1990 found that only 27 percent of firms with fewer than 10 employees offered health benefits, and only 73 percent of firms with 10 to 24 employees. In contrast, 98 percent of firms with 100 or more workers provided coverage in 1990. Note that workers who do not obtain coverage through their own employment may be insured in some other way, such as through a spouse's work-based coverage. This and the next figure show only the extent to which workers were covered through their own jobs.

Figure 45: Rate of Health Insurance Coverage by Size of Employer, 1991



Source: CRS analysis of March 1992 Current Population Survey

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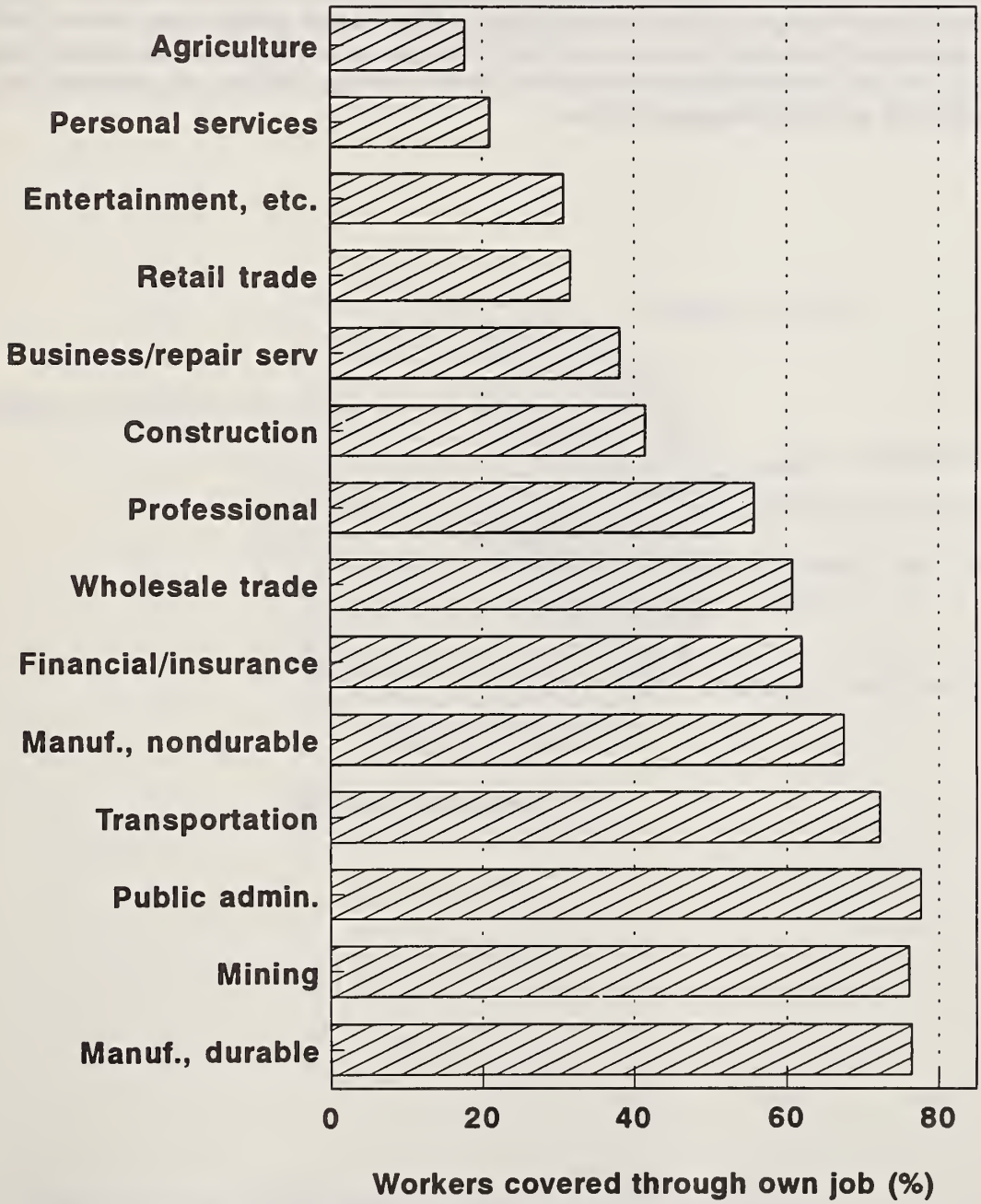
Figure 46: Rate of Health Insurance Coverage by Type of Industry, 1991

Industry type is also a strong determinant of coverage, though this factor may overlap with firm size. Workers in agriculture, personal services, and entertainment and recreation were least likely to have coverage through their own jobs in 1991, while those in public administration, mining, and manufacturing (durable goods) were most likely. Coverage is more prevalent in industries where benefits are established through collective bargaining. On the other hand, industries with a high proportion of seasonal or part-time workers are likely to have lower coverage rates.

Figure 46: Rate of Health Insurance Coverage by Type of Industry, 1991



Source: CRS analysis of March 1992 Current Population Survey

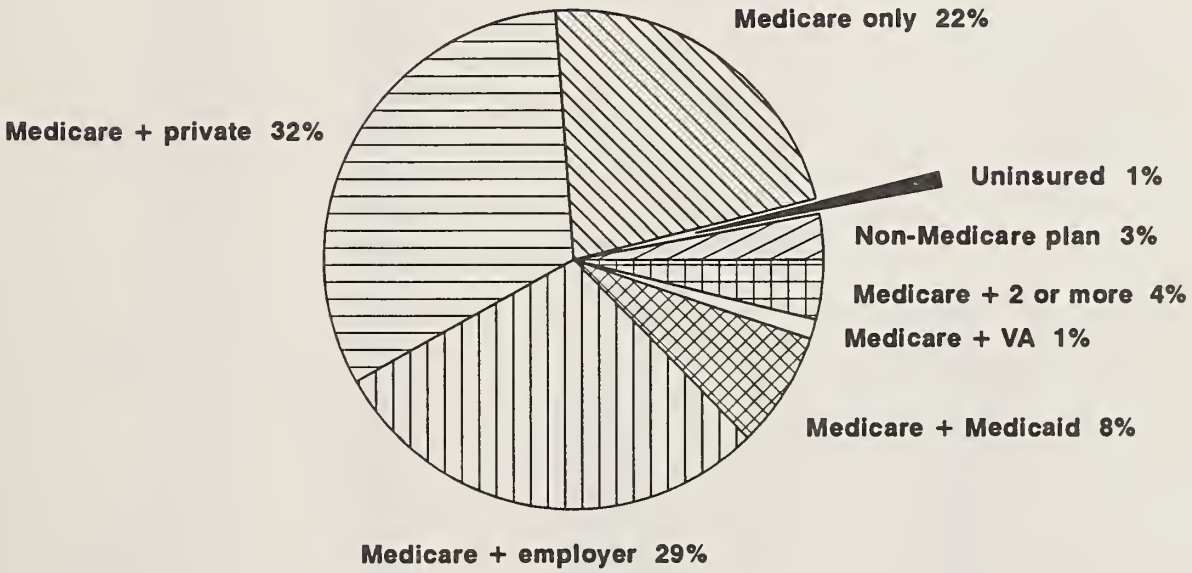
Figure 47: Sources of Health Care Coverage, Persons Aged 65 and Over, 1991

Nearly all elderly Americans have health insurance, chiefly through Medicare. About 3 percent of the elderly rely on non-Medicare coverage. These include Federal workers who retired before Medicare was required for Federal employees and who are therefore covered under the Federal Employees Health Benefit Program. Of the elderly covered by Medicare, 77 percent have some form of supplemental coverage. Most have retiree benefits or purchase private Medigap coverage on their own, while the low-income elderly may receive Medicaid. About 4 percent of the elderly have more than one type of supplemental coverage; note that this figure does not include those who have duplicate coverage within one coverage type, such as persons with multiple Medigap policies.

Figure 47: Sources of Health Care Coverage, Persons Age 65 and Over, 1991

Noninstitutionalized persons

Persons over 65
30.6 million



Source: CRS analysis of March 1992 Current Population Survey

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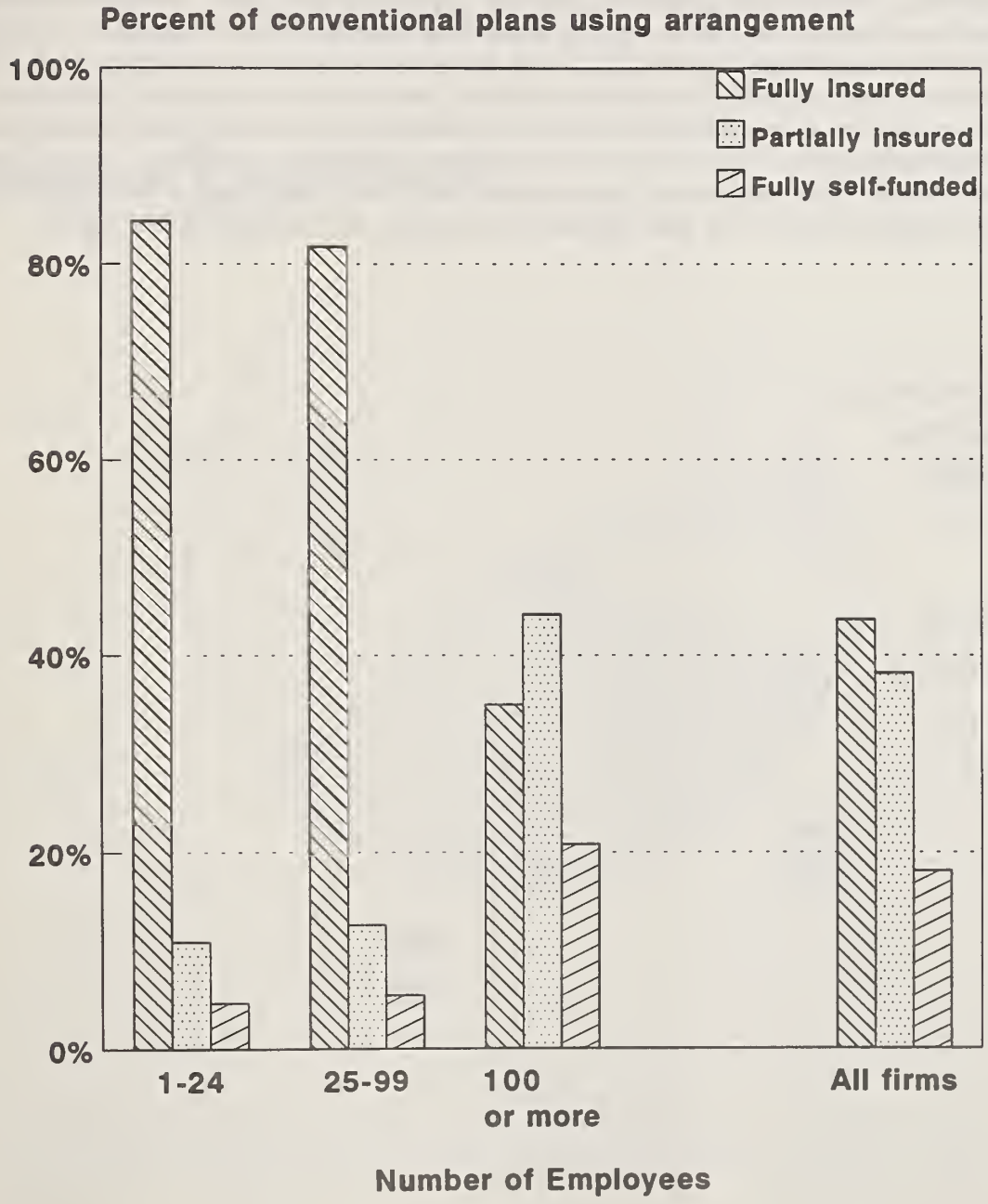
Figure 48: Insurance Funding Arrangement by Firm Size, 1990

One major trend in employer health benefit plain in recent years is a shift towards self-insurance, under which an employer directly assumes the financial risk for health care costs incurred by their employees. A self-insured firm may use an insurance company only to perform administrative tasks, such as claims processing, or it may carry on these functions in-house. Some firms are 'partially insured'; they retain responsibility for most health care costs but buy protection for extraordinary expenses. Because of the financial risks involved, smaller firms are more likely to buy full coverage from a health insurance company. Note that the figure shows only those firms that offer health benefits and does not include plans covered through health maintenance organizations (HMOs), which are almost always fully insured arrangements.

Figure 48: Insurance Funding Arrangement by Firm Size, 1990

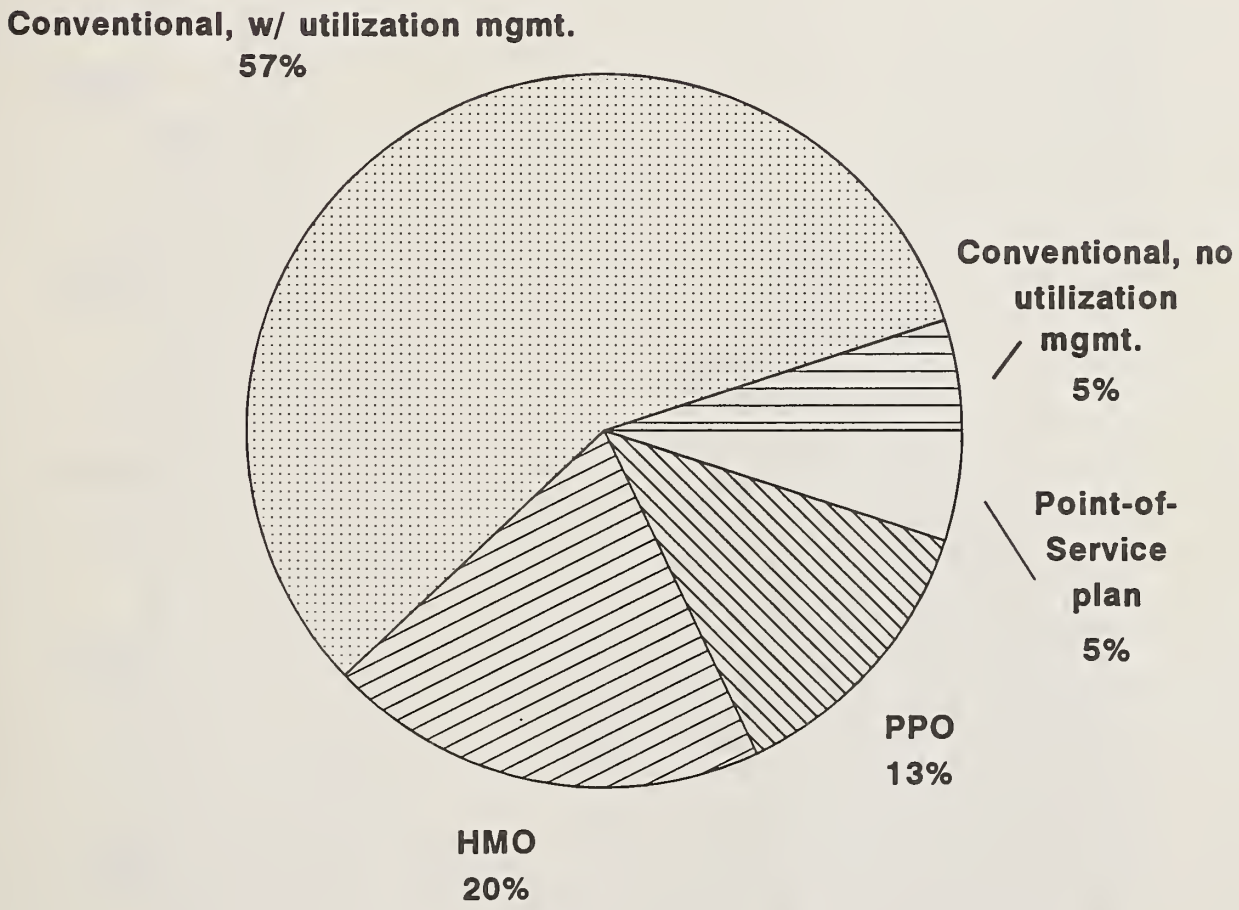


Source: Health Insurance Association of America, Employer Survey, 1990

Figure 49: Percent of Firms Using Alternate Delivery Models, 1990

A second major trend in the last two decades has been the growth of alternatives to traditional fee-for-service plans. Conventional plans provide uniform service coverage regardless of the particular medical providers used. Most now make use of some utilization management, such as pre-admission certification of inpatient hospital stays. Only 5 percent of workers are still in fee-for-service plans with no such controls. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) establish networks of affiliated providers; some HMOs employ physicians directly or own hospitals. An HMO will cover only services obtained through its own providers, except in an emergency. A PPO will cover non-network services, but provides financial incentives to use network providers. Point-of-service plans are a recent hybrid of the two, permitting some out-of-plan services like PPOs but incorporating some of the patient management techniques of HMOs. Use of the newer arrangements is more common in larger firms. Note that many firms offer a choice of plans to their workers; such a firm may appear in more than one category in the figure.

Figure 49: Enrollment in Employer Plans, by Type of Plan, 1990

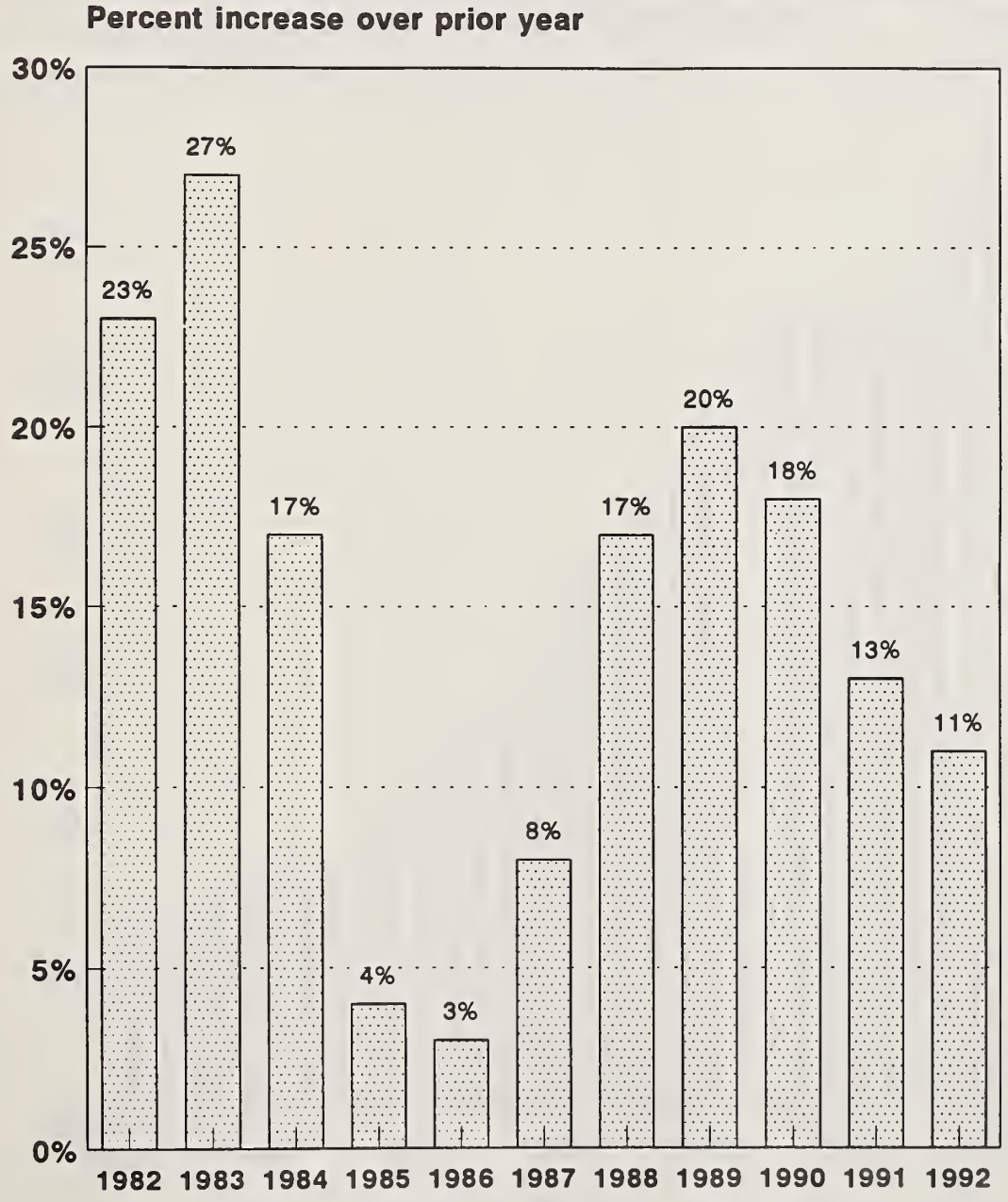


Source: Health Insurance Association of America, Employer Survey, 1990

Figure 50: Increase in Average Health Insurance Premium, 1982-92

Surveys of employers and insurers indicate that private health insurance premiums have risen sharply in the last several years. The figure represents the average annual increases reported in one survey of medium to large employers during the 1980s. Over the long term, health insurance premiums are thought to be subject to an 'underwriting cycle,' with periods of high rate increases alternating with periods of more moderate growth. Whether the high cycle of recent years has now peaked is not yet clear.

Figure 50: Increase in Average Health Insurance Premium, 1982-92

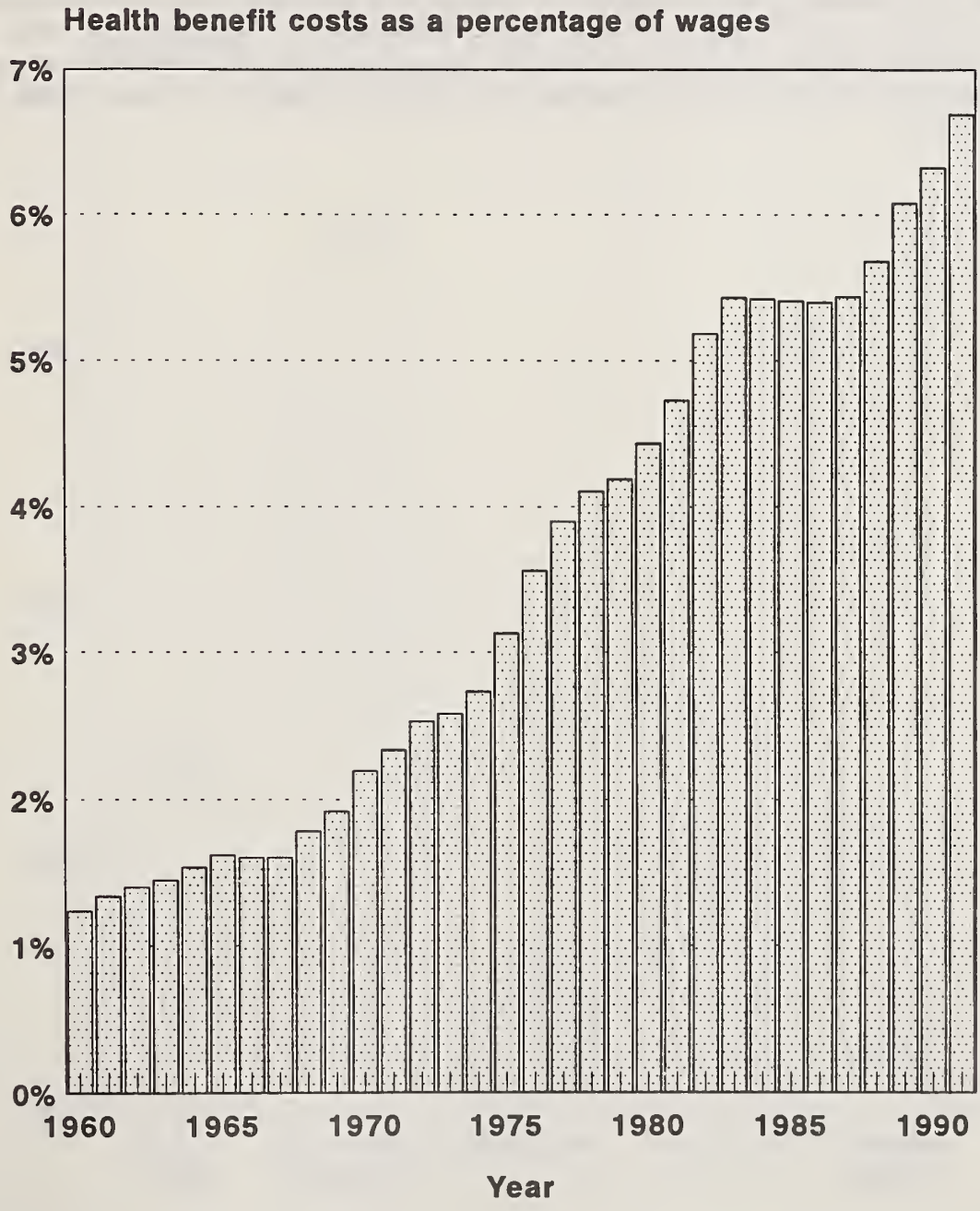


Source: Hay/Huggins Benefits Report

Figure 51: Employer Contribution to Group Health Insurance, 1960-91

Health benefit costs have emerged as a major component of employee compensation. Total employer spending on health benefits has grown from $3.4 billion in 1960 to $188 billion in 1991. Health costs kept pace with increases in wages in the mid-1980s, but have since grown more rapidly. As a result, health benefits have become an important issue in collective bargaining, and the costs are alleged to have affected the competitive position of some industries.

Figure 51: Employer Contribution to Group Health Insurance, 1960-1991

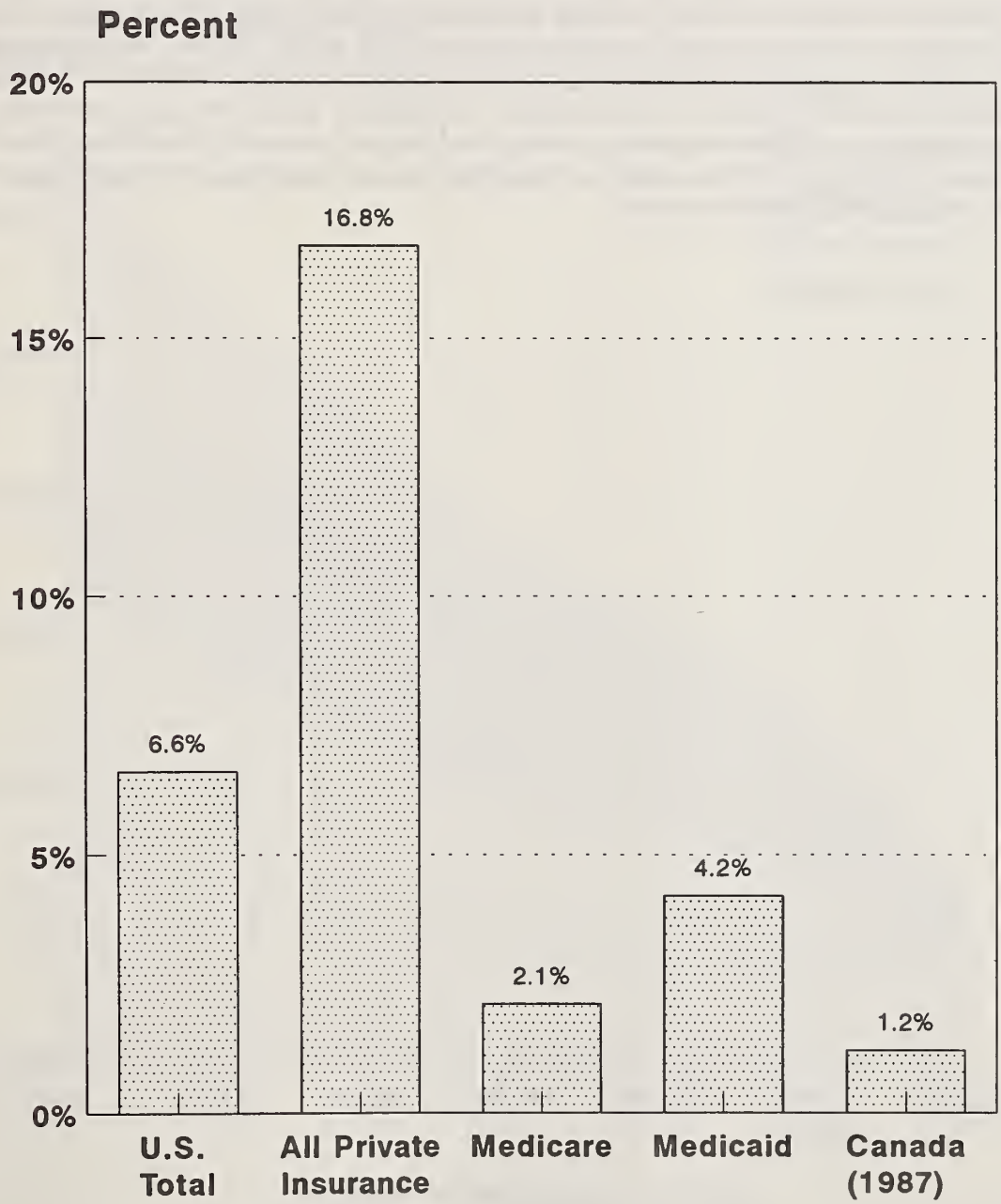


Source: U.S. Department of Commerce National Income and Product Accounts

Figure 52: Administrative Cost as a Percent of Benefits, Various Programs, 1991

The costs of any insurance program include administration, as well as direct service costs. Public programs generally have lower costs than private ones. Medicaid has somewhat higher costs than Medicare or the Canadian provincial programs, in part because of the expense of determining program eligibility. Among private insurance plans, individual coverage and coverage in small firms involves a higher administrative 'loading' than large group coverage. Note that the U.S. total and Canadian figures represent combined public and private administrative costs (and private insurers' net earnings) relative to total personal health expenditures.

Figure 52: Administrative Cost as Percent of Benefits, Various Programs, 1991

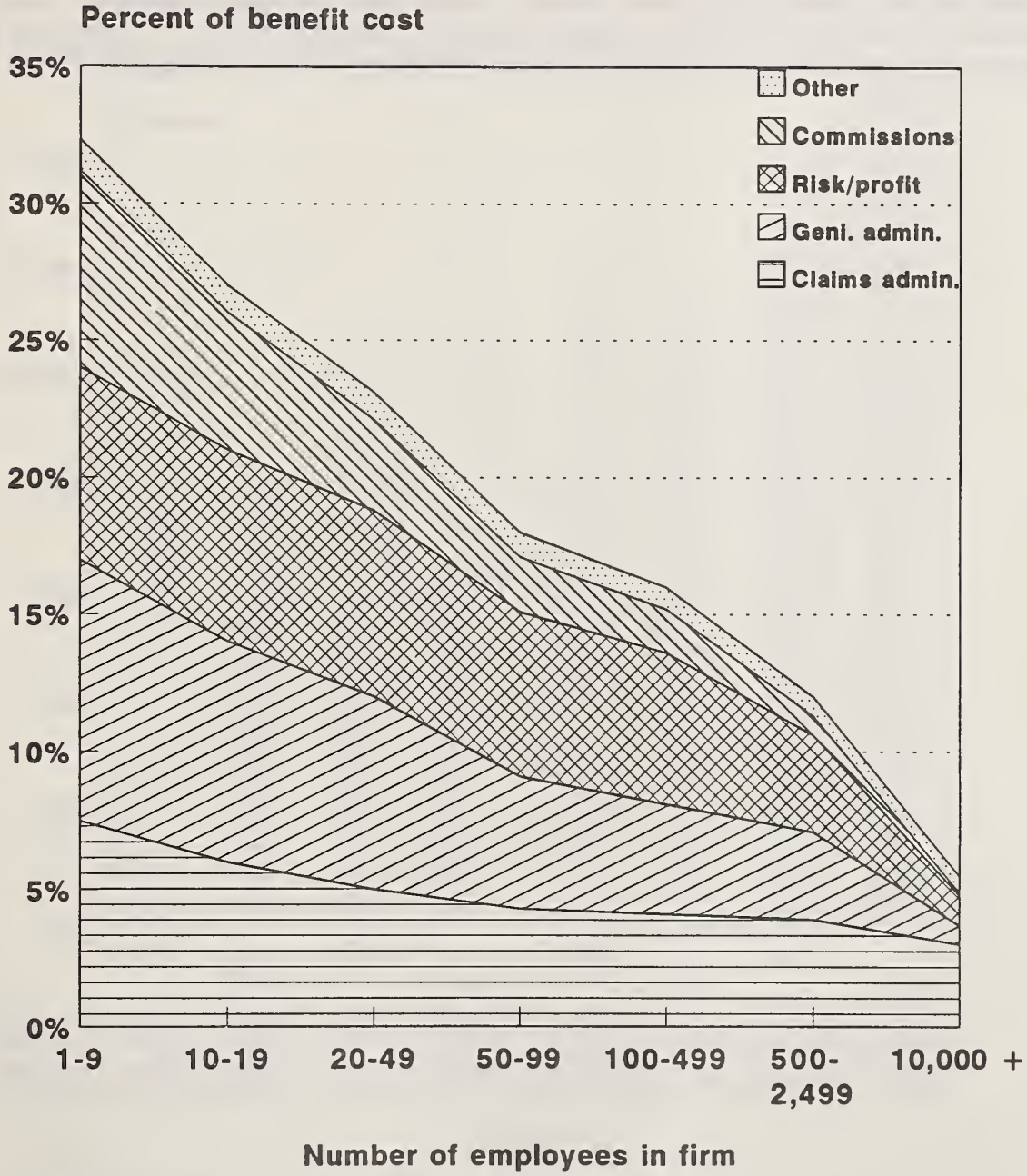


Source: U.S. data from HCFA Office of the Actuary; Canada from Health and Welfare Canada

Figure 53: Administrative Cost as a Percent of Benefit Costs by Size of Firm

Administrative costs are higher for small groups than for large ones, for several reasons. First, certain fixed costs, such as the cost of selling the policy, must be spread across a smaller number of members. Second, the insurer must perform some functions for small groups, such as member communications, that are commonly assumed by the employer in larger groups. Third, insurers commonly retain a higher proportion of small group premiums in reserves. Finally, there are some costs that are unique to the small group market. For example, if an insurer engages in medical underwriting for small groups, the costs of that activity will be reflected in the rates charged to those groups. In addition, there are some costs that apply only to groups that purchase insurance coverage and are not incurred by employers who choose to self insure. Self-insured plans entail no marketing expense and hence no commissions. They are also exempt from premium taxes.

Figure 53: Administrative Cost As a Percent of Benefit Costs by Size of Firm

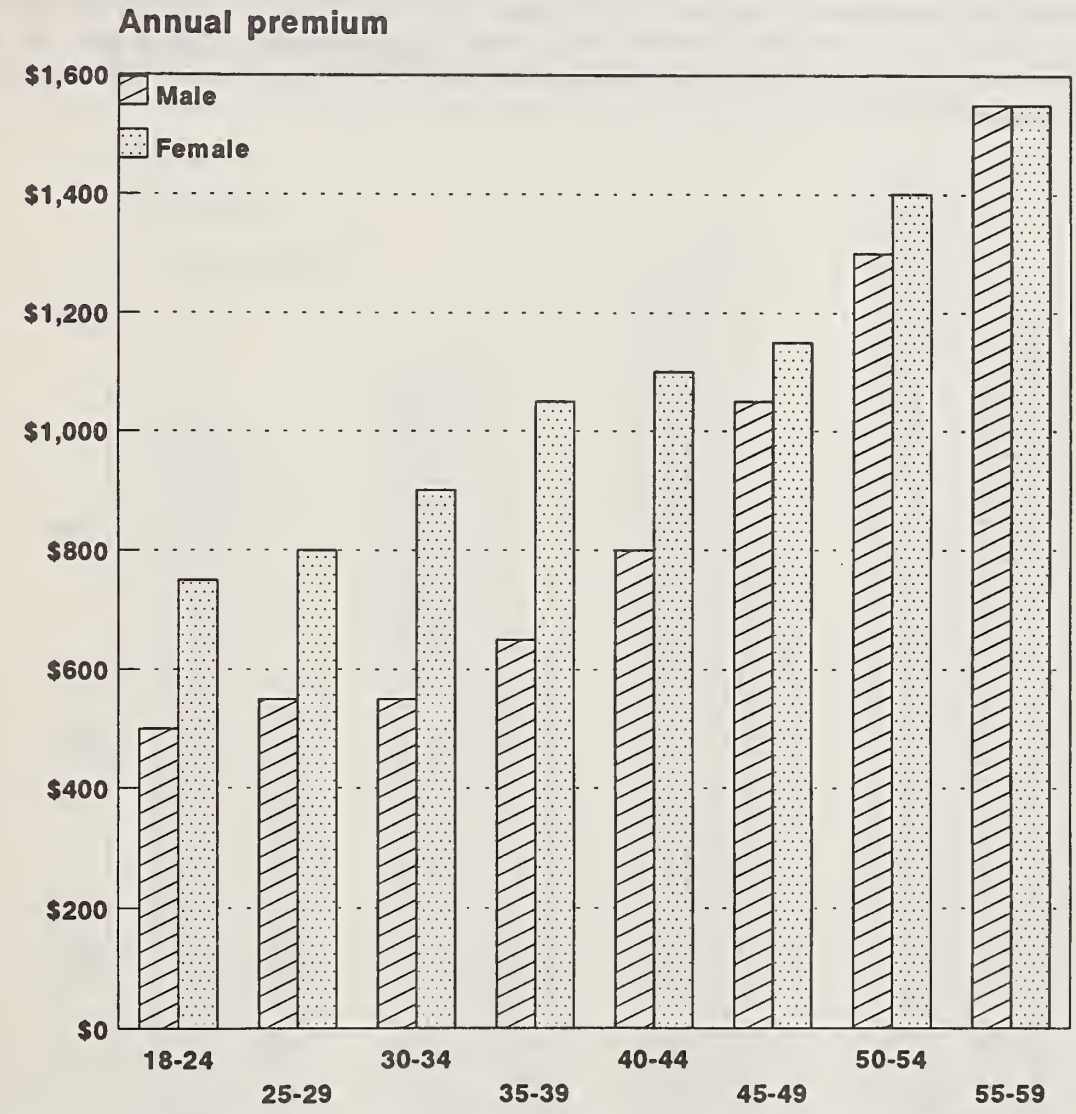


Source: Hay/Huggins Co. estimate, 1987

Figure 54: Typical Age/Sex Premium Range, Plan with Average Value of $1,000

Insurers selling health coverage to small groups charge different premium rates to different firms, depending on characteristics of the firm or its employees. Variables include industry type and location and the age and sex of workers. (Coverage for larger firms is usually 'experience rated,' with premiums based on the actual costs incurred by the firm's employees during a prior period.) The figure shows a typical range of age/sex variation, based on a number of insurers' rate books. Young women cost more than men of the same age, in part because of costs related to maternity, but this difference narrows among older adults.

Figure 54: Typical Age/Sex Premium Range, Plan with Average Value of $1,000



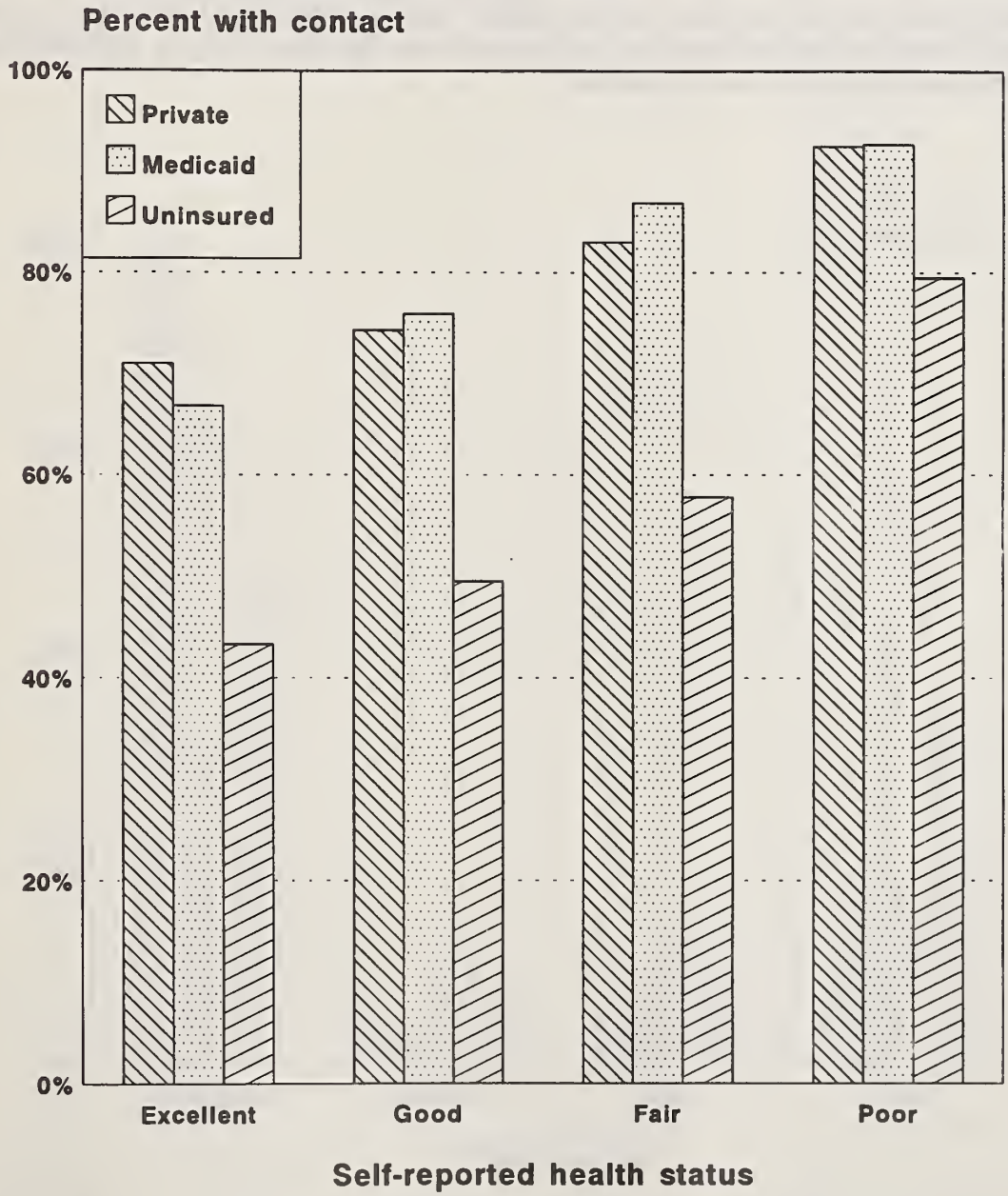
	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59
Male	$500	$550	$550	$650	$800	$1,050	$1,300	$1,550
Female	$750	$800	$900	$1,050	$1,100	$1,150	$1,400	$1,550

Source: CRS Health Insurance Premium Model

Figure 55: Percent of Non-Elderly with Ambulatory Physician Contact By Health Status and Insurance Coverage, 1987

The likelihood of obtaining medical services is related both to insurance coverage and to health status (as well as to other access factors). Persons who were covered by Medicaid or private insurance throughout 1987 were consistently more likely to have had at least one ambulatory physician visit than the uninsured with similar health status. Medicaid enrollees are about as likely as persons with private insurance to have at least one ambulatory physician contact during a year, and much more likely than the uninsured. Those who do see a physician have (after correction for health status) about the same number of visits as the privately insured.

Figure 55: Percent of Non-Elderly with Ambulatory Physician Contact by Health Status and Insurance Coverage, 1987

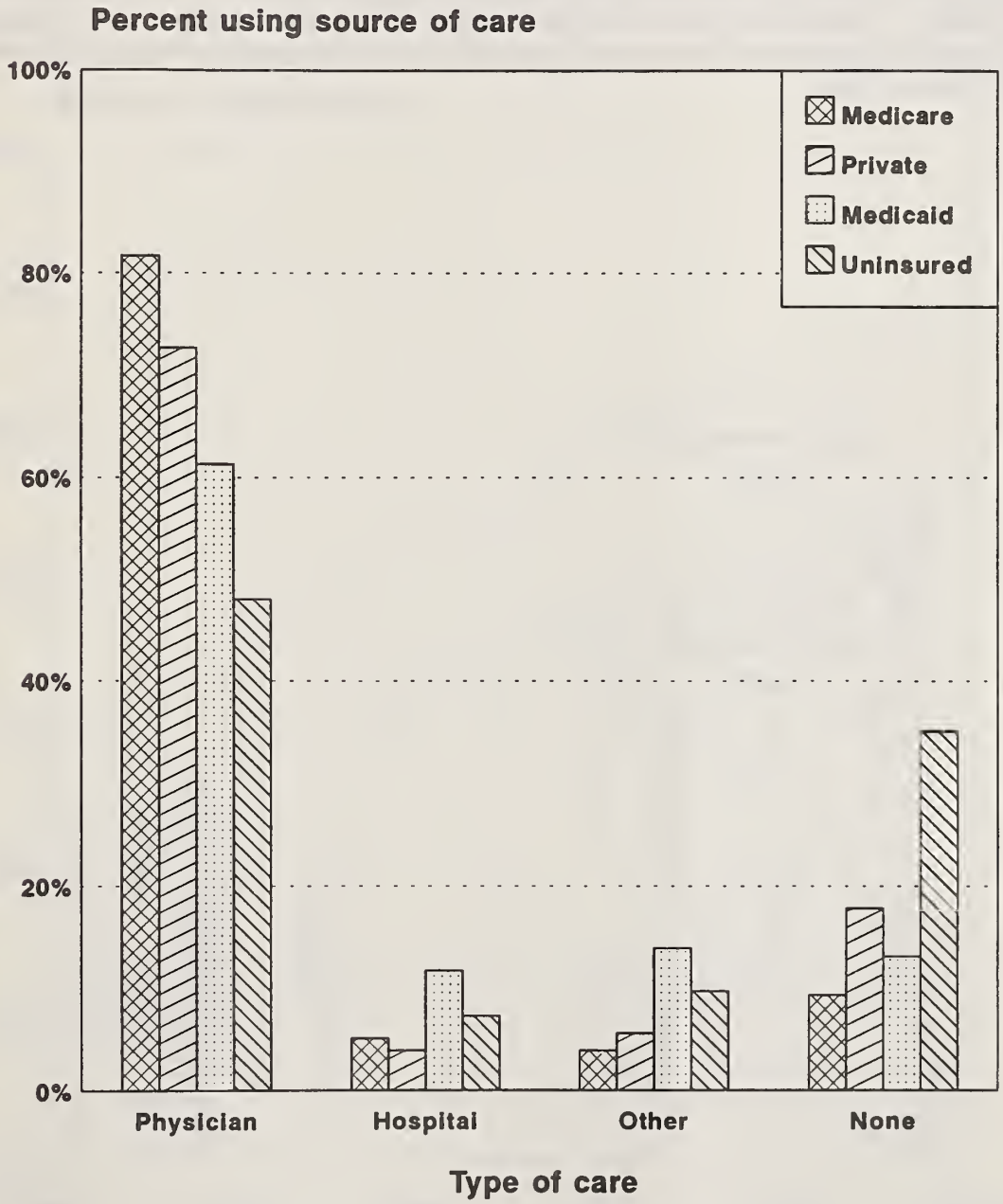


Source: CRS analysis of 1987 National Medical Expenditure Survey

Figure 56: Reported Usual Source of Care by Health Insurance Coverage, 1987

An alternative measure of basic access is the extent to which patients are able to establish an ongoing relationship with a regular source of care. Medicaid beneficiaries do relatively well on this measure; they are less likely than the privately insured, and much less likely than the uninsured, to report that they have no usual source of care. However, both Medicaid beneficiaries and the uninsured are more likely than the privately insured to report that their usual source of care is a hospital outpatient department or emergency room, or a community health center or similar facility, rather than an office-based physician. As might be expected, aged or disabled Medicare beneficiaries are the most likely to have an ongoing relationship with an office-based physician.

Figure 56: Reported Usual Source of Care by Health Insurance Coverage, 1987

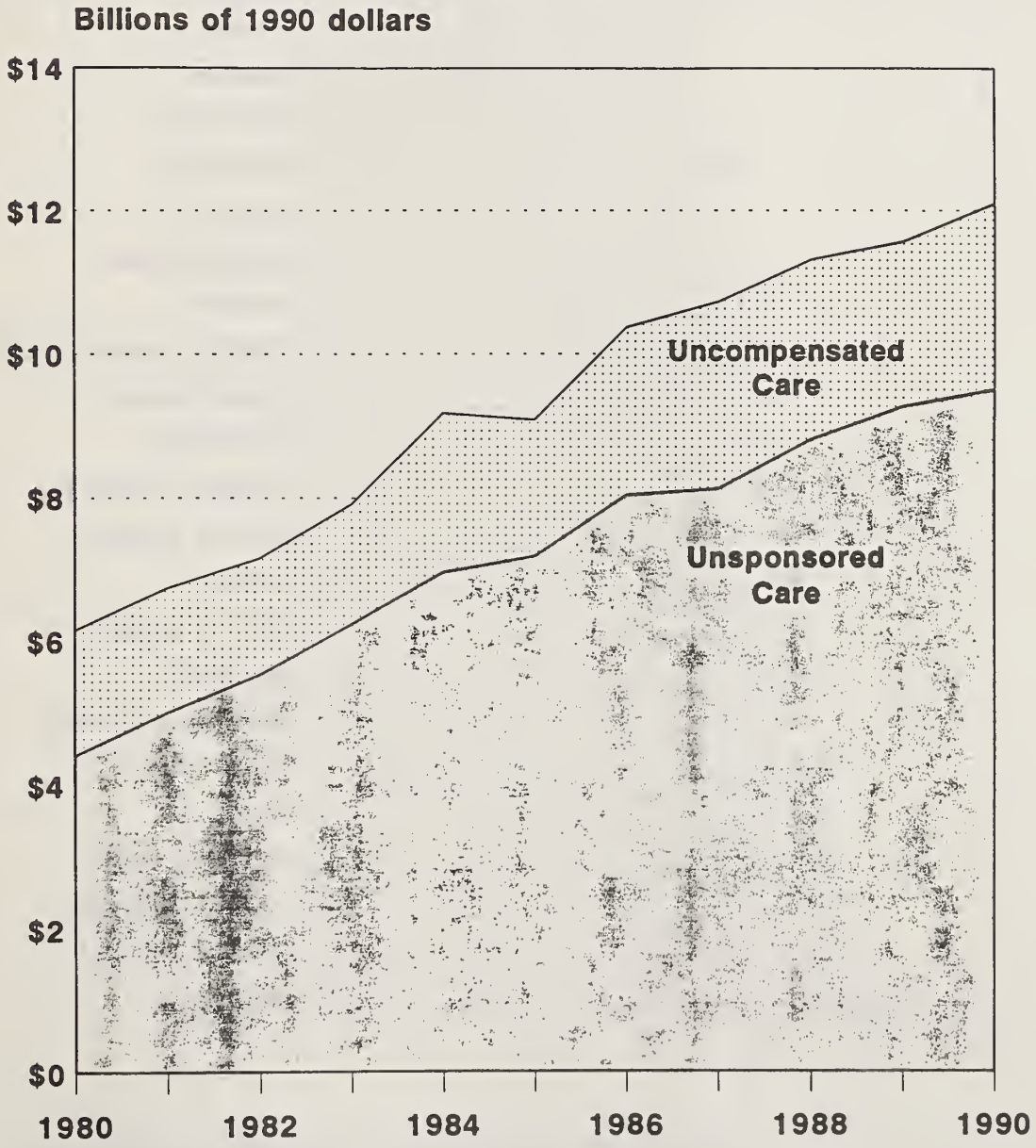


Source: Agency for Health Care Policy and Research, based on 1987 National Medical Expenditure Survey

Figure 57: Real Uncompensated and Unsponsored Care Provided by Hospitals, 1980-1990

The amount of uncompensated care -- the cost of bad debt and charity care provided by hospitals - has been rising during the 1980s, from $6.1 billion (in 1990 dollars) to $12.1 billion between 1980 and 1990. At the same time, "unsponsored" care -- the costs of uncompensated care that are not offset by payments from State and local governments -- grew from $4.4 billion to $9.5 billion. Unsponsored care rose more rapidly than uncompensated care, because only 21 percent of uncompensated care was offset by State and local governments in 1990, compared to 28 percent in 1980.

Figure 57: Hospital Uncompensated and Unsponsored Care in Constant 1990 Dollars, 1980-1990

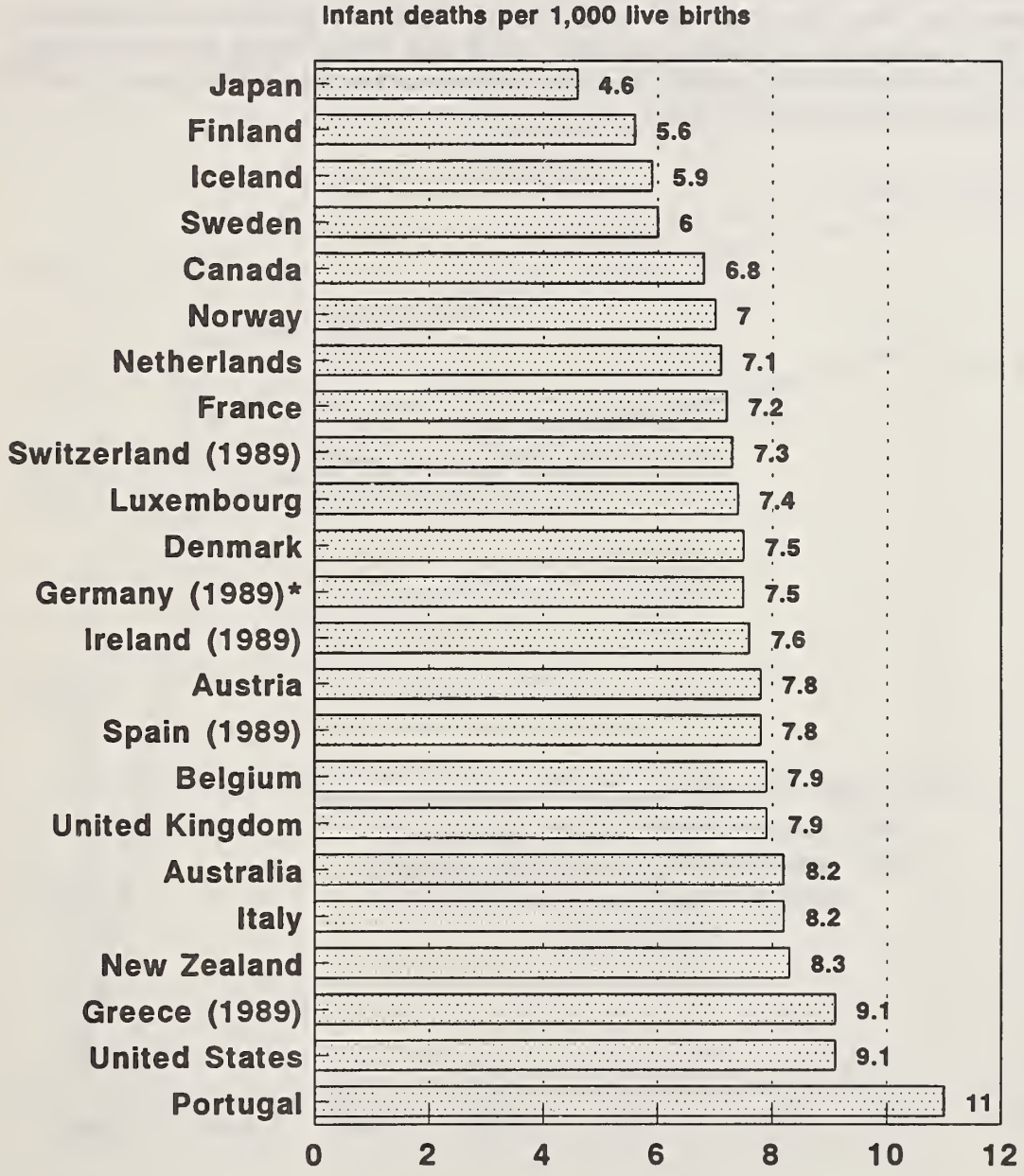


Source: CRS analysis of American Hospital Association data

Figure 58: Infant Mortality Rates in Selected Countries, 1990

The infant mortality rate in the United States -- the ratio of deaths in the first year of life to live births -- is higher than in many other developed nations and even some not classed as developed by the United Nations, such as Singapore and Hong Kong. In the United States, mortality rates are even higher for black infants: 17.7 infant deaths per thousand live births in 1989, as opposed to 8.2 per thousand for white infants.

Figure 58: Infant Mortality Rates in Selected Countries, 1990



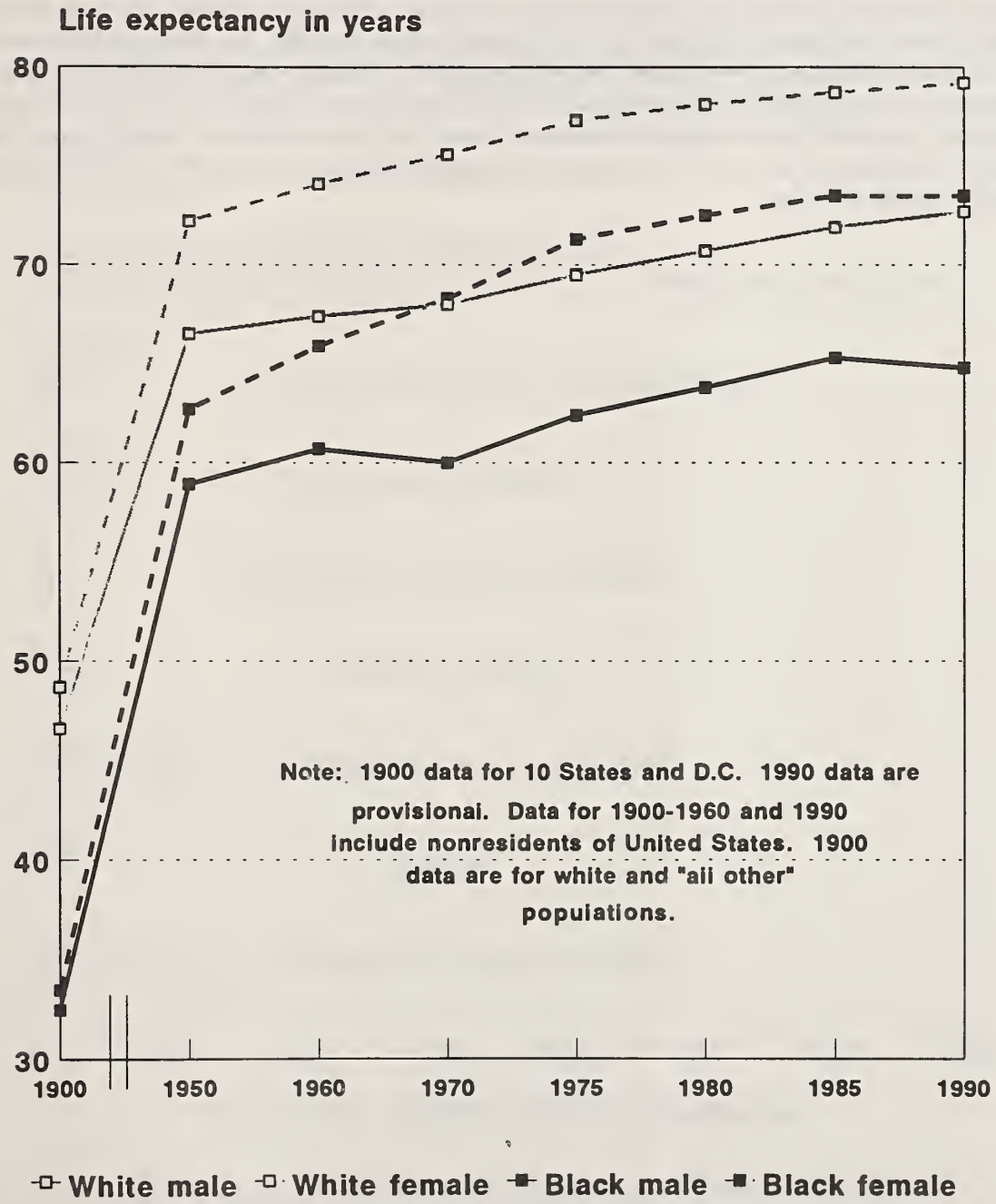
Source: Organization for Economic Cooperation and Development (OECD): OECD Health Data File, 1992

* Data for the former Federal Republic of Germany.

Figure 59: Life Expectancy at Birth by Race and Sex, U.S., 1900-90

Average life expectancy at birth in the United States has risen dramatically during the twentieth century, from 47.3 years for persons born in 1900 to an estimated 75.4 years for persons born in 1990. Most of the gain occurred in the years before 1950. While life expectancy has risen for all groups, black females still have a shorter life expectancy than white females, and the difference between black and white males is even greater. Life expectancy for black males actually dropped alightly in the late 1980s, from a peak of 65.6 years in 1984 to 64.8 years in 1989.

Figure 59: Life Expectancy at Birth by Race and Sex, U.S., 1900-1990

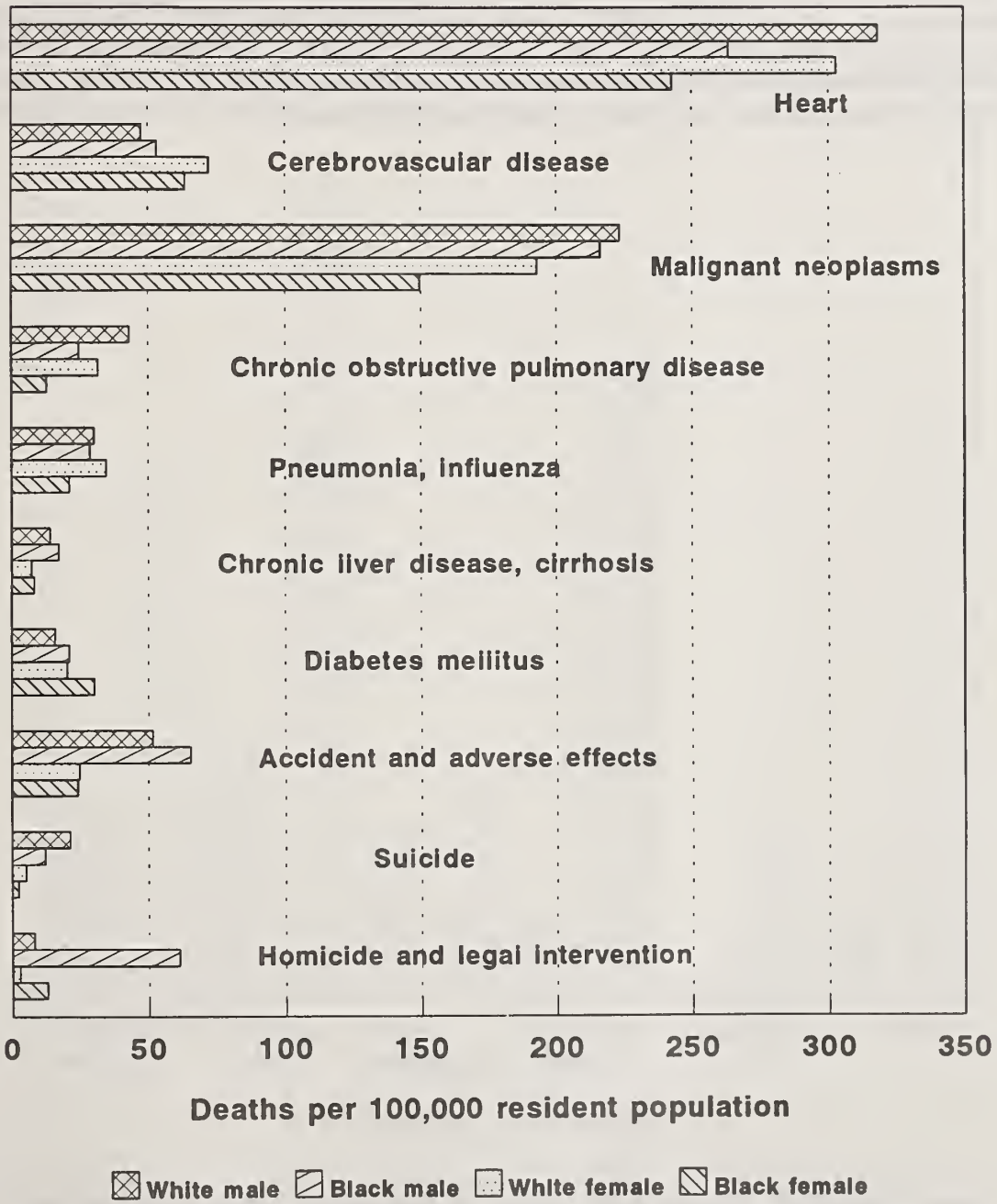


Source: U.S. Public Health Service. Health United States, 1991

Figure 60: Death Rates for Selected Causes of Death by Race and Sex, 1989

In 1989, heart disease and malignant neoplasms were the leading causes of death for both males and females and both blacks and whites. Other causes of death vary somewhat by race and sex. For example, males are more likely to die in accidents than of cerebrovascular disease. Blacks of both sexes are more likely to be victims of homicide or 'legal intervention' (such as injuries inflicted by police) than are whites. For black males, this was the fourth leading cause, as opposed to tenth for the population as a whole. National data on causes of death for the Hispanic population are not available. Sample data from 44 States and the District of Columbia indicate that homicide, HIV disease, and certain conditions arising in the perinatal period are more important causes of death for this population than for non-Hispanic whites. Preliminary data for 1991 indicate that HIV disease is now the ninth leading cause of death for all persons.

Figure 60: Death Rates for Selected Causes of Death by Race and Sex, 1989

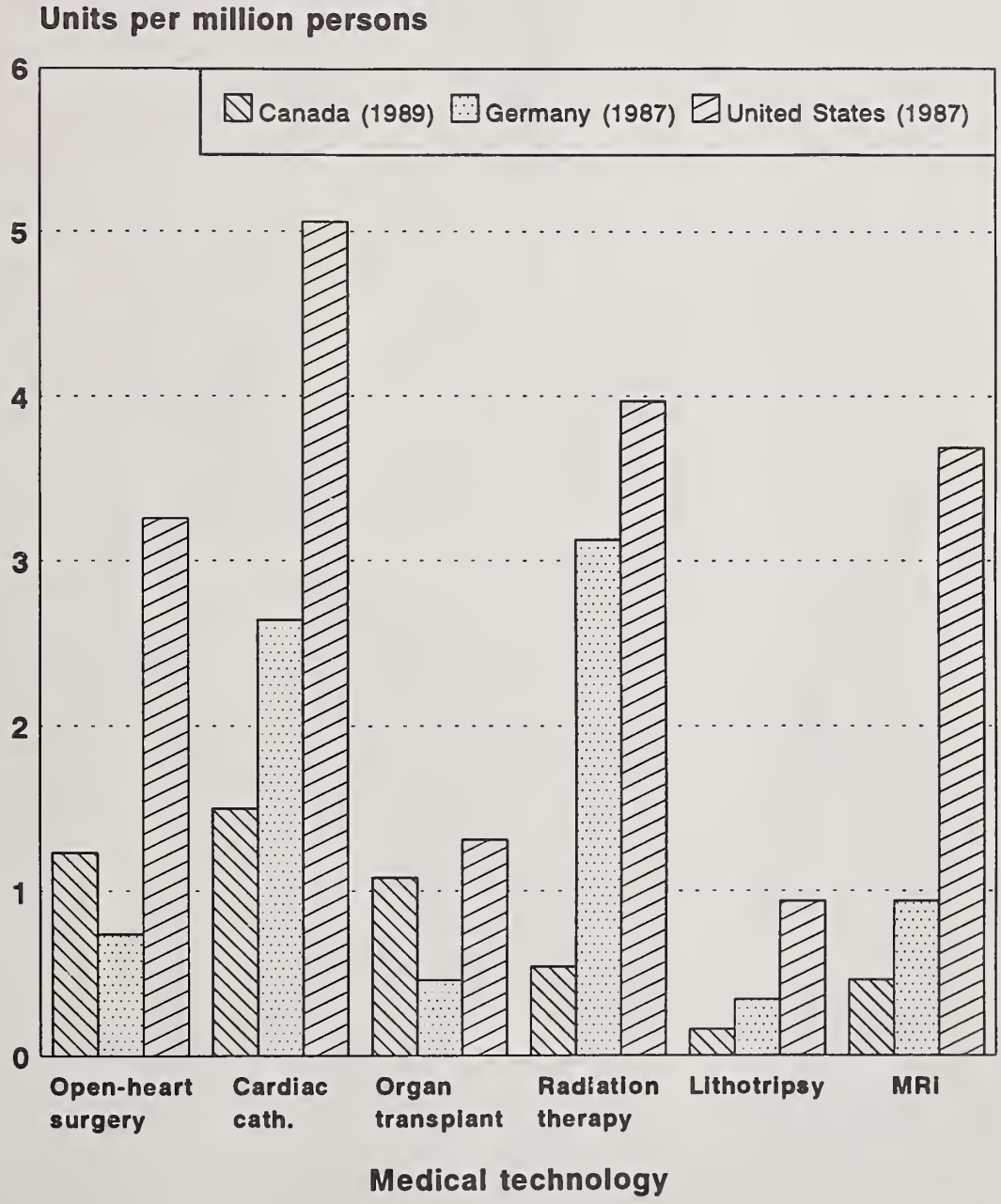


Source: National Center for Health Statistics, Advance Report of Final Mortality Statistics, 1989

Figure 61: Comparative Availability of Selected Medical Technologies, Selected Countries

Adoption of new medical technologies is widely believed to be a major factor in rising health care spending. New instruments and facilities spread much more rapidly in the United States than in other industrial nations, some of which (like Canada) have strict controls on the proliferation of technology. The U.S. had 900 magnetic resonance imaging (MRI) facilities in 1987, compared to just 12 in Canada two years later; relative to population, the U.S. had 8 times as many. On the other hand, Canada had nearly as many organ transplantation units per capita as the U.S., while the Federal Republic of Germany was far behind. In addition to general differences in adoption of technology, then, there are also differences in adoption of specific technologies that may relate to medical practice patterns or consumer preferences.

Figure 61: Comparative Availability of Selected Medical Technologies, Selected Countries



Source: Rublee, Dale. Medical Technology in Canada, Germany, and the United States, Health Affairs, 1989

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